

**Division of Medicaid
Office of the Governor
State of Mississippi
Drug Utilization Review (DUR) Board Meeting**



February 19, 2013 at 2:00pm

Woolfolk Building, Room 117

Jackson, MS

Prepared by:

The University of Mississippi School of Pharmacy

Evidence-Based DUR Initiative, MS-DUR

MS | DUR

Drug Utilization Review Board

Allison Bell, Pharm.D.
University of MS School of Pharmacy
2500 North State St.
Jackson, MS 39216
Term Expires: June 30, 2015

Cherise McIntosh, Pharm.D.
UMC Dept of Pharmacy
2500 North State St.
Jackson, MS 39216
Term Expires: June 30, 2014

Logan Davis, Pharm.D.
Vital Care, Inc.
1170 NE Industrial Park Rd
Meridian, MS 39301
Term Expires: June 30, 2013

Mark Reed, M.D. (Chair)
University of MS Medical Center
2500 North State Street, Trailer 16
Jackson, MS 39216
Term Expires: June 30, 2013

Edgar Donahoe, M.D.
Indianola Family Medicine Group
122 Baker Street
Indianola, MS 38751
Term Expires: June 30, 2013

Sue H. Simmons, M.D.
Maben Medical Clinic
49 Turner St.
Maben, MS 39750
Term Expires: June 30, 2015

Lee Greer, M.D.
IMA-Tupelo
845 S. Madison St.
Tupelo, MS 38801
Term Expires: June 30, 2015

Dennis Smith, R.Ph.
Polk's Discount Pharmacy
1031 Star Rd
Brandon, MS 39042
Term Expires: June 30, 2014

Antoinette M. Hubble, M.D.
McComb Children's Clinic
300 Rawls Dr. Ste 100
McComb, MS 39648
Term Expires: June 30, 2014

Cynthia Undesser, M.D.
MS Children's Home Services
402 Wesley Ave
Jackson, MS 39202
Term Expires: June 30, 2014

Sarah Ishee, Pharm.D.
Fred's Pharmacy
1000 Broadway Dr., Suite 50
Hattiesburg, MS 39401
Term Expires: June 30, 2015

Vicki Veazey, R.Ph.
MS State Hospital , Bldg 50
Whitfield, MS 39193
Term Expires: June 30, 2013
Vicky Veazey, R.Ph.

2013 DUR Board Meeting Dates

February 19, 2013
August 15, 2013

May 16, 2013
November 21, 2013

As with any analysis, great efforts are made to ensure that the information reported in this document is accurate. The most recent administrative claims data available are being used at the time the reports are generated, which includes the most recent adjudication history. As a result, values may vary between reporting periods and between DUR Board meetings, reflecting updated reversals and claims adjustments.

Only Mississippi Medicaid beneficiaries with fee-for-service claims are included in the analyses, including dual enrollees with Medicare Part D. MississippiCAN data is not being reported unless otherwise specified. Further, reported dollar figures represent reimbursement to providers and are not representative of overall Medicaid costs.

Please refer to the Mississippi Division of Medicaid website for the official PDL list.

**MISSISSIPPI DIVISION OF MEDICAID
OFFICE OF THE GOVERNOR
DRUG UTILIZATION REVIEW BOARD
AGENDA**

February 19, 2013

Welcome	Mark Reed, M.D. (Chair)
Old Business	Mark Reed, M.D. (Chair)
Approval of November 2012 Meeting Minutes	<i>page 6</i>
Resource Utilization Review	Kyle D. Null, Pharm.D., Ph.D.
Top 15 Drug Classes and Top 25 Drug Detail – Amount Paid*	<i>pages 12, 21</i>
Top 15 Drug Classes and Top 25 Drug Detail – Number of Claims	<i>pages 27, 36</i>
Pharmacy Program Update	Shannon Hardwick, R.Ph.
Medicaid Update	
New Business	Kyle D. Null, Pharm.D., Ph.D.
<i>Special Analysis Projects</i>	<i>page 44</i>
Medicaid Managed Care Projected Shift Analysis	Ben Banahan, Ph.D.
Monitoring Suboptimal Asthma Control	<i>page 50</i>
Zolpidem Drug Safety Communication	<i>page 56</i>
DM and Codeine-containing Cough Syrup Utilization	<i>page 58</i>
<i>Exceptions Monitoring</i>	
Exceptions Monitoring Criteria Recommendations	<i>page 63</i>
Next Meeting Information	Mark Reed, M.D. (Chair)

DUR Board Meeting Minutes

**MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE NOVEMBER 15, 2012 MEETING**

DUR Board Members:	Present	Absent
Allison Bell, Pharm.D.	✓	
Logan Davis, Pharm.D.	✓	
Edgar Donahoe, M.D.	✓	
Lee Greer, M.D.		✓
Antoinette M. Hubble, M.D.	✓	
Sarah Ishee, Pharm.D.	✓	
Cherise McIntosh, Pharm.D.	✓	
Mark Reed, M.D. (Chair)	✓	
Sue Simmons, M.D.	✓	
Dennis Smith, R.Ph.	✓	
Cynthia Undesser, M.D.	✓	
Vicky Veazey, R.Ph.	✓	
Total	11	1

Also Present:**DOM Staff:**

Shannon Hardwick, R.Ph., DOM Clinical Pharmacist, DUR Coordinator; David Dzielak, DOM Executive Director

MS-DUR Staff:

Kyle Null, Pharm.D., Ph.D., Clinical Director; Nancy Jones, Project Coordinator, Mary Morgan Alexander, UM Student on DUR rotation.

ACS Staff:

Leslie Leon, Pharm.D.

Visitors:

Kim Elston, Novo Nordisk; Robert Pearce, Teva; Callista Goheen, MedImmune; Jeff Cameron, Dyax Corp.; Brian Berhow, Sunovion; Phil Hecht, Abbott; Joey Giamfortone, Reckitt Benckiser.

Call to Order:

Dr. Mark Reed, Chairman of the Board, called the meeting to order at 2:02 pm. Dr. Reed welcomed the new Board members and asked for introductions by all of the Board members. Dr. Reed then asked members for additions or corrections to minutes. Dr. Undesser made a motion to approve the minutes from the August 2012 meeting. Motion seconded by Ms. Veazey and was unanimously approved.

Resource Utilization Review:

Dr. Null reviewed the resource utilization report and oriented the new Board members to the reporting format. Dr. Null briefly reviewed the hemostatic drug class following a question by Mr. Smith about fluctuation in monthly prescription fills. Dr. Null explained the fluctuation was primarily driven by a variation in the number of claims per patient. Since hemostatics dosing is a function of the patient's

body weight and blood levels, it is not uncommon to see multiple distinct claims for the same drug. Additionally, the monthly prescription benefit limit for these patients is relaxed because of their EPSTD status. Dr. Donahoe asked how children were put into that category. Ms. Hardwick and Dr. Leon explained how the EPSTD functioned as it relates to SmartPA and prescription benefits. Ms. Hardwick further discussed the EPSTD benefit to the Board, explaining that SmartPA would allow for prescriptions beyond the monthly benefit limit for children with qualifying chronic diagnoses. Dr. Null continued the resource utilization review by pointing out the increased use of amphetamines and adrenals, namely budesonide and prednisolone, due to expected seasonal trends. Dr. Null concluded by stating that the drug utilization was fairly consistent with notable exceptions being preferred drug list (PDL) status changes and seasonal fluctuations. There were no further comments or questions about the resource utilization report.

Pharmacy Program Update:

Ms. Hardwick began the Medicaid update by asking the Board members to sign conflict of interest and confidentiality forms, as well as travel reimbursement forms. Ms. Hardwick reviewed two changes which become effective January 1, 2013. First, the new PDL will be in effect and will be revised once a year instead of twice yearly. Second, Medicare Part D changes to benzodiazepine and barbiturate coverage will affect Medicaid beneficiaries who are dually eligible for Part D. CMS announced that Medicare Part D plans will have to cover benzodiazepines as well as barbiturates for beneficiaries with diagnoses of epilepsy, cancer, and chronic mental health disorders. Ms. Hardwick mentioned that the Board would need to elect a co-chair at the February DUR Board meeting.

Dr. Null reviewed the DUR process and Board responsibilities for the new Board members. Dr. Null highlighted the main duties of the DUR Board: oversight for the Division of Medicaid, evaluating practitioner prescribing patterns based on clinical guidelines, developing exceptions monitoring criteria, recommending educational interventions, and reviewing policy issues. Dr. Null mentioned that some CMS initiatives, including a move towards measuring quality in the Medicaid program, would be the focus of the upcoming year. Dr. Null further explained the exceptions monitoring process and how educational interventions relate to exceptions monitoring. Dr. Null also reviewed some typical special project examples for the new Board members. He mentioned that there has also been an increased focus on issues relating to fraud, abuse, and misuse of drugs that the Board will continue to review in the coming year. Dr. Null closed by discussing the current focus of the education program related to giving Medicaid providers program information helpful to their practice, but the future focus would shift to include more educational outreach related to quality initiatives in the Medicaid program driven from exceptions monitoring.

New Business:***Special analysis projects:******Revatio Use in Children and Adolescents***

Dr. Null reviewed the FDA safety labeling change related to a dose-dependent increase in mortality in children and adolescents using Revatio. MS-DUR reviewed the prescription claims data and found that only 7 beneficiaries under the age of 18 were on the drug. Because of the nature of this FDA safety labeling change, no action was being requested from the Board and the DOM was working to implement an age edit to deny Revatio at the point-of-sale (POS).

Monitoring Suboptimal Respiratory Control

At the October P&T meeting, the issue was raised as to how short-acting beta2 agonist rescue inhalers were being used in the Mississippi Medicaid population. The P&T asked that the DUR Board review this

issue. Dr. Null discussed the importance of finding an operational definition that could be used to identify “inappropriate” use of rescue inhalers in administrative claims data. He noted that after a review of the literature, the Pharmacy Quality Alliance (PQA) had proposed to the National Quality Forum (NQF) quality measures related to suboptimal asthma control with and without appropriate controller therapy. Dr. Null reviewed the two measures and noted that adopting a nationally recognized framework to assess this issue would be fruitful since there is already supporting evidence in the literature of its use. He explained that the measures would be aggregated at the health plan (i.e., Medicaid) level and that targeted provider education could be utilized to help address possible suboptimal asthma control. He also mentioned that this process is similar to the way exceptions monitoring are handled. Dr. Null mentioned that quality-based initiatives would be an increasing focus of the DUR Board’s activities over the coming year. Dr. Null said that MS-DUR is seeking a directive from the DUR Board to review the asthma quality indicators as described for the February DUR Board meeting. Dr. Ishee raised the issue of possibly denying short acting beta2 at the POS based on days supply or the number of canisters dispensed over a period of time. Dr. Null informed the Board that Medicaid currently allows up to two canisters per month on the basis that one could be used at school and one at home. Dr. Donahoe mentioned Medicaid had tried intervention with asthma patients in the past and that patients go through periods of exacerbation, where they will need access to rescue inhalers. Dr. Donahoe mentioned that prescribers do not have access to information on how the patient is filling the medications. The Board discussed the availability of inhalers with and without counters. Dr. Donahoe said it would be a good idea to send out reminders based on clinical guidelines about the importance of controller medications to encourage providers to prescribe controller therapy when appropriate. He also mentioned that it would be helpful to let providers know that it is being monitored by DOM as a quality measure.

Dr. Simmons asked about the providing patient education information on how to use the inhaler properly. Mr. Smith asked about existing retrospective criteria on how to identify frequent rescue inhaler use and concurred that monitoring asthma control based on the outlined criteria is something MS-DUR should do. The benefit vs. harm of implementing a “hard edit” was discussed and the general consensus of the Board was that such an edit may not be in the best interest of the patient experiencing an exacerbation and that it may be better handled through DUR initiatives.

Dr. Davis asked about the availability of benchmarks set by PQA or other groups. Dr. Null replied that part of the process would be to establish a benchmark on these quality indicators and to educate providers that the goal should be to improve the quality measure relative to the benchmark. He continued that reaching “100%” of a quality measure is not necessarily the goal, because such a goal would ignore individual treatment decisions, possible contraindications, etc. Dr. Null asked the Board if there was agreement on the definitions of suboptimal respiratory control quality measures. The Board members agreed.

Dr. Bell asked if there would be any value in having MS-DUR to evaluate ER visits and hospital stays associated with the exceptions identified by the quality measure. Dr. Hubble raised some issues of identifying ER visits and hospital stays. Dr. Donahoe commented on inclusion criteria considerations for inpatient and outpatient hospitalizations. Dr. Davis asked about the value of evaluating plan cost in addition to ER visits and hospital stays, emphasizing the value of having cost savings data driven from moving the quality measure through benefit control measures and education. Mr. Smith asked about the feasibility of partnering with a pharmaceutical company to provide unbranded educational material to physician offices and patients, since the primary educational outreach from MS-DUR was directly to prescribers and not ordinarily focused on specific patient care issues (e.g., appropriate inhaler

technique). Dr. Null described the educational materials provided to providers and noted that they were generally about the Medicaid prescription drug benefit and specific therapeutic considerations derived from exceptions monitoring.

Provider Outreach for Potential Control Substance Abuse/Misuse

Dr. Null reviewed the history of DUR Board activity related to monitoring controlled substance abuse and misuse. He noted that this topic had been discussed over several quarterly meetings. At previous meetings, the DUR Board had provided feedback on criteria used to identify potential cases of controlled substance abuse/misuse to send to Medicaid's Program Integrity (PI) for further review for lock-in. The current criteria for PI review are based on beneficiaries who receive select controlled substance prescriptions from a combination of 7 unique prescribers and pharmacies. Dr. Null mentioned that the Board had previously discussed lowering the "cut point" for the purpose of educational outreach to providers. MS-DUR is seeking a formal directive from the DUR Board to start a prescriber educational outreach letter campaign about patients receiving select controlled substances from 4 unique pharmacies and prescribers in a 90 day period. Dr. Ishee noted that the data being reviewed was only Medicaid fee-for-service claims and did not include managed care or cash paying claims. Dr. Null confirmed that and also noted that some prescribers have access to the prescription drug monitoring program (PDMP). He further noted that this initiative would be a supplement to the PDMP program and not a replacement. Dr. Simmons said that she remembered receiving a letter from the DUR about a patient who was shopping pharmacies for Darvocet. Dr. Davis asked if Medicaid could put a comment on the third-party return message about the patient being monitored by PI. Dr. Leon replied that Xerox and Medicaid are working on edits to allow ease of use for the pharmacists. Dr. Null noted that the current criteria exclude beneficiaries with a diagnosis of cancer. Some discussion ensued regarding whether to exclude beneficiaries with a diagnosis of sickle cell; however, the general consensus was to leave sickle cell beneficiaries in the criteria. Dr. Ishee noted that letters sent based on these criteria would be valuable for pharmacies. Dr. Donahoe motioned to accept the 4 prescriber / 4 pharmacies the limit for provider letters and to notify PDMP to review patient use of drugs when MS-DUR identifies beneficiaries with high potential for abuse. Dr. Reed seconded the motion and all voted in favor.

Update on Suboxone SmartPA Implementation

Ms. Hardwick reviewed the history of the Suboxone protocol and noted that the implementation of the new electronic protocol is going well. Ms. Hardwick noted that the primary purpose of moving the Suboxone criteria from manual prior authorization (PA) to electronic was to reduce the administrative burden on the PA unit and provider's offices. She noted that MS-DUR and DOM is continuously monitoring and reviewing the claims data to identify potential problems with the criteria. Ms. Hardwick mentioned that the electronic process has eased PA process, has shortened the time that a patient waited to receive a prescription as compared to the manual PA, and has not adversely affected patient access to Suboxone based on the data provided in the report. Ms. Hardwick also noted that she has had very positive response from prescribers and pharmacies regarding the new protocol. Ms. Hardwick discussed the work to try and step patients off of the drug by using a cumulative 24 month limit for Suboxone and dosage titration limits. Dr. Null concluded by stating that the manual PA process conversion to electronic has gone very well and has not adversely affected patient access based on the data presented in the report.

Exceptions Monitoring

Dr. Null explained exceptions letters from MS-DUR and what they look like. Dr. Null also mentioned that future exceptions monitoring would include criteria based on the quality measures being reviewed,

citing the asthma measures as an example. Recommendations were taken as a block vote. The motion was made by Dr. Reed and seconded by Mr. Smith. The motion was unanimously approved.

Other Business

Ms. Hardwick noted Ms. Clark could not be at the DUR Board meeting because she was in deposition and Terri Kirby was absent due to some required training. Ms. Hardwick also acknowledged that Dr. Dzielak, the Division of Medicaid Executive Director, was present for a portion of the meeting.

Next Meeting Information:

Dr. Reed announced next meeting date is February 21, 2013 at 2:00 P.M. and thanked everyone for making the effort to attend the DUR Board meeting in order to have a quorum. The meeting adjourned at 3:10 P.M.

Submitted,
Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report

Top 15 Drugs by Class

Top 25 Drug Detail

By Amount Paid* and Number of Claims

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Amount Paid*†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Antipsychotics (atypical And Typical)	\$2,737,912.28	8,233	\$2,892,319.71	8,831	\$1,704,511.72	5,817	\$7,334,743.71	22,881
Aripiprazole	\$1,024,085.81	1,549	\$1,071,075.57	1,660	\$769,931.94	1,182	\$2,865,093.32	4,391
Quetiapine	\$637,607.98	1,557	\$671,549.70	1,648	\$368,560.43	1,018	\$1,677,718.11	4,223
Risperidone	\$325,144.89	2,898	\$341,353.10	3,101	\$216,719.23	2,386	\$883,217.22	8,385
Olanzapine	\$278,163.32	496	\$313,106.87	538	\$166,756.16	300	\$758,026.35	1,334
Paliperidone	\$189,571.68	167	\$179,805.40	161	\$28,381.49	37	\$397,758.57	365
Ziprasidone	\$89,912.19	233	\$98,430.85	259	\$41,807.31	103	\$224,856.95	595
Asenapine	\$75,894.09	146	\$83,860.03	169	\$42,843.12	82	\$202,597.24	397
Lurasidone	\$65,793.04	104	\$72,754.26	119	\$19,944.27	33	\$158,491.57	256
Haloperidol	\$22,650.97	482	\$26,576.46	554	\$10,485.35	255	\$59,712.78	1,291
Clozapine	\$20,417.43	127	\$20,459.49	138	\$9,111.26	69	\$49,988.18	334
Chlorpromazine	\$24,765.32	232	\$24,585.08	224	\$18,618.68	180	\$44,933.94	434
Iloperidone	\$11,458.90	20	\$13,135.65	23	\$4,026.12	6	\$28,620.67	49
Perphenazine	\$5,073.94	70	\$4,840.76	72	\$3,150.44	48	\$13,065.14	190
Fluphenazine	\$2,701.33	58	\$2,745.97	60	\$595.00	20	\$6,042.30	138
Prochlorperazine	\$2,215.88	116	\$2,113.12	126	\$648.20	40	\$4,977.20	282
Thioridazine	\$999.83	37	\$1,256.45	44	\$1,087.18	33	\$3,343.46	114
Trifluoperazine	\$1,289.04	28	\$1,103.09	23	\$621.74	13	\$3,013.87	64

Note: Resource Utilization Report Currently Contains Only Fee For Service Medicaid Claims

* Dollar figures represent reimbursement to pharmacies and are not representative of overall Medicaid costs.

† Molecule names accounting for less than \$500 in quarterly amount paid are not shown

Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Amount Paid*†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Loxapine	\$909.26	11	\$1,436.64	18	\$563.54	6	\$2,909.44	35
Pimozide	\$658.28	6	\$744.88	6	\$380.88	4	\$1,784.04	16
Thiothixene	\$503.84	20	\$621.29	25	\$279.38	11	\$1,404.51	56
Adrenals	\$2,070,975.22	16,161	\$2,071,801.60	17,171	\$1,868,312.27	14,272	\$6,011,089.09	47,604
Budesonide	\$1,685,231.68	4,078	\$1,683,322.26	4,080	\$1,555,962.34	3,698	\$4,924,516.28	11,856
Prednisolone	\$123,820.02	7,178	\$132,599.40	8,040	\$121,519.97	7,294	\$377,939.39	22,512
Fluticasone	\$74,939.91	511	\$69,570.00	475	\$61,612.45	428	\$206,122.36	1,414
Budesonide-formoterol	\$54,985.24	251	\$63,019.90	285	\$33,834.15	152	\$151,839.29	688
Beclomethasone	\$47,023.86	345	\$43,864.97	319	\$34,947.93	252	\$125,836.76	916
Mometasone	\$27,758.12	202	\$26,426.02	190	\$25,474.87	183	\$79,659.01	575
Formoterol-mometasone	\$23,954.35	111	\$18,457.56	85	\$13,777.43	63	\$42,631.49	198
Methylprednisolone	\$14,107.35	1,148	\$15,478.56	1,264	\$7,930.19	584	\$37,516.10	2,996
Prednisone	\$9,607.59	1,808	\$9,512.75	1,876	\$6,868.19	1,232	\$25,988.53	4,916
Dexamethasone	\$4,287.14	363	\$3,947.11	391	\$2,878.01	272	\$11,112.26	1,026
Hydrocortisone	\$1,952.94	83	\$2,508.74	83	\$1,705.23	64	\$6,166.91	230
Fludrocortisone	\$1,556.81	57	\$1,462.38	59	\$1,177.32	39	\$4,196.51	155
Flunisolide Nasal	\$1,689.92	24	\$1,502.32	21	\$624.19	11	\$3,816.43	56
Amphetamines	\$1,455,935.85	8,656	\$1,501,148.29	8,964	\$1,280,498.47	7,575	\$4,237,582.61	25,195
Amphetamine-dextroamphetamine	\$765,489.66	4,518	\$791,611.75	4,712	\$661,116.40	3,857	\$2,218,217.81	13,087
Lisdexamfetamine	\$663,897.64	3,985	\$681,136.93	4,090	\$594,188.61	3,573	\$1,939,223.18	11,648
Dextroamphetamine	\$26,548.55	153	\$28,399.61	162	\$25,193.46	145	\$80,141.62	460

Note: Resource Utilization Report Currently Contains Only Fee For Service Medicaid Claims

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Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Amount Paid*†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Hemostatics	\$1,107,297.39	75	\$1,228,361.06	81	\$1,553,373.34	59	\$3,889,031.79	215
Antihemophilic Factor	\$553,952.91	13	\$380,835.41	13	\$595,921.73	19	\$1,530,710.05	45
Anti-inhibitor Coagulant Complex	\$85,452.60	2	\$611,914.03	8	\$271,341.61	3	\$968,708.24	13
Antihemophilic Factor-von Willebrand Fa	\$378,046.86	7	\$84,343.89	3	\$314,402.79	7	\$776,793.54	17
Coagulation Factor Viia	\$63,367.82	2	\$84,495.64	4	\$291,639.81	11	\$439,503.27	17
Coagulation Factor Ix	\$18,860.94	2	\$58,880.83	3	\$77,918.37	5	\$155,660.14	10
Tranexamic Acid	\$6,550.03	45	\$7,489.48	48	\$2,079.97	13	\$16,119.48	106
Aminocaproic Acid	\$1,066.23	4	\$369.74	1	\$69.06	1	\$1,505.03	6
Anorex., Resp. & Cerebral Stim., Misc.	\$1,039,563.25	6,115	\$1,064,535.53	6,357	\$945,050.41	5,547	\$3,049,149.19	18,019
Methylphenidate	\$698,747.98	4,067	\$723,669.76	4,236	\$631,636.82	3,691	\$2,054,054.56	11,994
Dexmethylphenidate	\$320,323.73	2,024	\$327,838.60	2,098	\$307,223.67	1,847	\$955,386.00	5,969
Modafinil	\$11,516.79	12	\$8,992.30	14	\$5,286.62	7	\$25,795.71	33
Armodafinil	\$4,516.50	10	\$4,034.87	9	\$903.30	2	\$9,454.67	21
Caffeine	\$4,458.25	2					\$4,458.25	2
Anticonvulsants, Miscellaneous	\$973,197.39	10,305	\$1,064,197.64	11,084	\$658,467.59	6,450	\$2,695,862.62	27,839
Divalproex Sodium	\$163,725.04	1,604	\$173,491.74	1,703	\$110,031.89	1,126	\$447,248.67	4,433
Oxcarbazepine	\$132,610.10	1,017	\$139,091.52	1,057	\$109,939.76	839	\$381,641.38	2,913
Pregabalin	\$141,614.58	643	\$152,512.29	695	\$52,316.41	244	\$346,443.28	1,582
Levetiracetam	\$108,363.09	1,270	\$117,102.95	1,367	\$88,044.29	1,004	\$313,510.33	3,641
Gabapentin	\$94,255.02	2,542	\$106,521.22	2,844	\$38,819.33	1,068	\$239,595.57	6,454
Lamotrigine	\$72,239.77	857	\$79,294.12	915	\$54,055.74	579	\$205,589.63	2,351

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Drug Class Report
Top 15 Classes By Quarterly Amount Paid*†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Lacosamide	\$65,538.76	150	\$73,785.09	165	\$52,017.61	116	\$191,341.46	431
Topiramate	\$59,561.72	1,129	\$63,566.48	1,189	\$39,083.26	671	\$162,211.46	2,989
Vigabatrin	\$25,734.93	6	\$43,594.92	8	\$30,723.55	4	\$100,053.40	18
Carbamazepine	\$32,402.06	583	\$33,077.90	608	\$19,852.54	379	\$85,332.50	1,570
Rufinamide	\$27,911.46	35	\$31,835.98	39	\$25,239.93	31	\$84,987.37	105
Felbamate	\$21,674.36	25	\$21,887.54	27	\$16,723.36	20	\$60,285.26	72
Zonisamide	\$12,467.72	268	\$11,773.36	278	\$9,409.32	210	\$33,650.40	756
Valproic Acid	\$8,090.57	168	\$8,632.74	179	\$6,979.20	154	\$23,702.51	501
Tiagabine	\$7,008.21	8	\$8,029.79	10	\$5,231.40	5	\$20,269.40	23
Beta-adrenergic Agonists	\$841,788.88	13,951	\$908,149.66	15,086	\$635,039.80	11,465	\$2,384,978.34	40,502
Albuterol	\$501,860.22	12,528	\$532,414.41	13,542	\$403,303.35	10,522	\$1,437,577.98	36,592
Fluticasone-salmeterol	\$284,174.52	1,137	\$308,983.53	1,218	\$202,033.66	815	\$795,191.71	3,170
Albuterol-ipratropium	\$47,036.82	202	\$52,681.03	227	\$19,960.39	89	\$119,678.24	518
Levalbuterol	\$5,597.67	28	\$9,377.72	32	\$7,790.41	24	\$22,765.80	84
Formoterol	\$931.36	6	\$2,426.64	11	\$1,114.90	7	\$4,472.90	24
Terbutaline	\$1,587.16	48	\$1,655.06	54	\$225.82	6	\$3,468.04	108
Arformoterol	\$601.13	2	\$611.27	2	\$611.27	2	\$1,823.67	6
Pirbuterol	\$297.28	2	\$450.21	3	\$300.14	2	\$1,047.63	7
Cephalosporins	\$759,147.45	10,898	\$846,010.36	11,997	\$778,630.12	9,911	\$2,383,787.93	32,806
Cefdinir	\$368,174.34	4,711	\$427,161.19	5,461	\$394,606.14	4,929	\$1,189,941.67	15,101
Cefixime	\$220,123.50	870	\$226,440.74	894	\$224,714.03	833	\$671,278.27	2,597

Note: Resource Utilization Report Currently Contains Only Fee For Service Medicaid Claims

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† Molecule names accounting for less than \$500 in quarterly amount paid are not shown

Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Amount Paid*†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Cefprozil	\$101,401.43	1,731	\$112,595.87	1,878	\$104,587.72	1,715	\$318,585.02	5,324
Cephalexin	\$46,226.30	2,949	\$46,516.30	3,033	\$34,647.05	1,952	\$127,389.65	7,934
Ceftriaxone	\$7,532.22	124	\$15,596.33	124	\$6,459.98	78	\$29,588.53	326
Cefuroxime	\$8,325.79	391	\$9,419.07	454	\$6,852.80	302	\$24,597.66	1,147
Cefadroxil	\$4,263.45	104	\$4,597.26	108	\$3,960.31	83	\$12,821.02	295
Cefepime	\$1,699.99	6	\$2,180.77	24	\$1,409.48	5	\$5,290.24	35
Ceftibuten	\$863.00	2	\$577.94	2	\$577.94	2	\$2,018.88	6
Cefaclor	\$508.50	9	\$489.14	11	\$300.19	6	\$1,297.83	26
Cefazolin	\$28.93	1	\$149.77	4	\$322.96	4	\$501.66	9
Leukotriene Modifiers	\$871,270.88	5,198	\$721,279.19	4,297	\$555,079.68	3,312	\$2,147,629.75	12,807
Montelukast	\$870,321.46	5,190	\$720,869.19	4,293	\$635,960.30	3,780	\$2,146,066.83	12,793
Zafirlukast	\$814.85	7	\$410.00	4	\$203.50	2	\$1,428.35	13
Corticosteroids	\$740,830.94	6,245	\$754,580.84	6,360	\$583,081.66	4,843	\$2,078,493.44	17,448
Mometasone Nasal	\$542,463.60	4,088	\$546,267.70	4,136	\$417,069.22	3,141	\$1,505,800.52	11,365
Ciprofloxacin-dexamethasone Otic	\$142,605.40	1,002	\$146,419.13	1,023	\$131,135.30	911	\$420,159.83	2,936
Dexamethasone-tobramycin Ophthalmic	\$19,268.95	225	\$24,200.36	229	\$12,161.10	125	\$55,630.41	579
Hydrocortisone/neomycin/polymyxin B	\$11,347.42	418	\$12,589.84	461	\$9,094.36	369	\$33,031.62	1,248
Fluticasone Nasal	\$3,749.21	37	\$4,011.35	41	\$2,427.05	26	\$10,187.61	104
Triamcinolone Nasal	\$3,798.79	31	\$3,122.57	26	\$2,143.69	18	\$9,065.05	75
Loteprednol Ophthalmic	\$2,891.80	21	\$3,256.88	21	\$1,310.04	7	\$7,458.72	49
Tobramycin Ophthalmic	\$2,571.40	184	\$2,103.85	217	\$2,130.58	169	\$6,805.83	570

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Amount Paid*†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Dexamethasone/neomycin/polymyxin B	\$2,745.08	177	\$2,360.76	159	\$1,620.39	117	\$6,726.23	453
Hydrocortisone/neomycin/polymyxin B	\$2,737.29	26	\$2,405.01	23	\$1,449.43	14	\$6,591.73	63
Prednisolone Ophthalmic	\$1,669.51	119	\$2,009.00	138	\$909.94	63	\$4,588.45	320
Flunisolide Nasal	\$1,689.92	24	\$1,502.32	21	\$624.19	11	\$3,816.43	56
Acetic Acid-hydrocortisone Otic	\$1,565.68	10	\$1,560.20	10	\$645.28	5	\$3,771.16	25
Ciprofloxacin-hydrocortisone Otic	\$856.45	5	\$1,027.74	6	\$1,024.74	6	\$2,908.93	17
Colistin/hc/neomycin/thonzonium Otic	\$433.98	7	\$1,046.47	14	\$533.36	7	\$2,013.81	28
Prednisolone-sulfacetamide Sodium Oph	\$778.69	15	\$942.63	15	\$184.09	6	\$1,905.41	36
Beclomethasone Nasal	\$668.96	4	\$833.95	5	\$167.99	1	\$1,670.90	10
Fluorometholone Ophthalmic	\$473.91	24	\$512.84	24	\$312.57	14	\$1,299.32	62
Bacitracin/neomycin/polymyxin B Ophth	\$436.63	9	\$484.22	10	\$231.21	6	\$1,152.06	25
Loteprednol-tobramycin Ophthalmic	\$716.45	5	\$157.19	1	\$157.19	1	\$1,030.83	7
Insulins	\$722,173.65	2,968	\$814,334.37	3,256	\$400,177.07	1,712	\$1,936,685.09	7,936
Insulin Glargine	\$221,463.68	878	\$252,578.29	944	\$111,388.51	470	\$585,430.48	2,292
Insulin Aspart	\$163,728.29	592	\$202,585.19	702	\$131,194.78	460	\$497,508.26	1,754
Insulin Aspart-insulin Aspart Protamine	\$103,363.53	237	\$110,198.01	279	\$45,217.14	118	\$258,778.68	634
Insulin Detemir	\$84,669.60	319	\$95,683.46	352	\$43,031.94	183	\$223,385.00	854
Insulin Isophane-insulin Regular	\$52,674.90	258	\$53,056.41	274	\$19,057.39	97	\$124,788.70	629
Insulin Isophane	\$41,007.33	334	\$40,508.67	343	\$22,972.51	202	\$104,488.51	879
Insulin Regular	\$25,723.50	238	\$25,297.18	227	\$10,130.27	111	\$61,150.95	576
Insulin Lispro	\$21,193.21	84	\$25,481.18	106	\$13,197.22	56	\$59,871.61	246
Insulin Lispro-insulin Lispro Protamine	\$5,578.10	15	\$6,682.72	18	\$3,420.09	12	\$15,680.91	45

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Amount Paid*†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Insulin Glulisine	\$2,771.51	13	\$2,263.26	11	\$567.22	3	\$5,601.99	27
Antineoplastic Agents	\$774,724.65	1,465	\$706,858.68	1,478	\$432,980.98	773	\$1,914,564.31	3,716
Everolimus	\$186,020.32	24	\$112,157.94	16	\$127,136.64	16	\$425,314.90	56
Sunitinib	\$108,795.00	12	\$97,376.30	10	\$38,164.82	4	\$244,336.12	26
Leuprolide	\$72,549.48	52	\$99,116.50	56	\$62,304.06	38	\$210,102.16	146
Erlotinib	\$81,982.08	15	\$54,925.18	10	\$22,730.54	4	\$159,637.80	29
Imatinib	\$48,289.50	7	\$76,035.49	12	\$27,066.56	5	\$151,391.55	24
Capecitabine	\$57,400.93	18	\$59,753.20	19	\$18,948.07	7	\$136,102.20	44
Letrozole	\$30,604.50	78	\$31,235.60	80	\$18,847.04	46	\$80,687.14	204
Megestrol	\$25,546.66	228	\$27,229.28	226	\$15,692.28	124	\$68,468.22	578
Anastrozole	\$27,895.22	116	\$30,466.34	122	\$8,914.36	36	\$67,275.92	274
Nilotinib	\$24,193.44	3	\$16,128.96	2	\$24,588.55	3	\$64,910.95	8
Sorafenib	\$18,580.14	2	\$18,580.14	2	\$18,580.14	2	\$55,740.42	6
Methotrexate	\$19,621.36	648	\$20,359.88	664	\$9,160.44	312	\$49,141.68	1,624
Dasatinib	\$8,640.31	1	\$30,241.54	4	\$8,640.31	1	\$47,522.16	6
Temozolomide	\$18,606.42	4	\$15,124.51	5	\$4,469.41	2	\$38,200.34	11
Pazopanib	\$6,846.05	1	\$13,692.10	2	\$6,846.05	1	\$27,384.20	4
Tretinoin	\$2,815.05	1	\$5,630.10	2	\$7,810.06	2	\$16,255.21	5
Tamoxifen	\$5,957.74	124	\$5,569.90	114	\$2,880.32	58	\$14,407.96	296
Topotecan	\$6,041.72	2	\$6,222.91	2			\$12,264.63	4
Hydroxyurea	\$3,992.82	65	\$3,190.06	57	\$2,679.01	52	\$9,861.89	174
Lapatinib	\$9,013.52	2					\$9,013.52	2

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Amount Paid*†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Mercaptopurine	\$1,917.49	25	\$2,581.36	32	\$2,475.06	30	\$6,973.91	87
Bicalutamide	\$1,848.14	18	\$2,343.04	22	\$1,717.12	16	\$5,908.30	56
Bevacizumab	\$5,143.33	1					\$5,143.33	1
Exemestane	\$1,249.24	6	\$402.72	2	\$2,054.68	10	\$3,706.64	18
Flutamide	\$665.96	4	\$666.08	4			\$1,332.04	8
Mitotane					\$948.16	1	\$948.16	1
Goserelin			\$795.92	2			\$795.92	2
Central Nervous System Agents, Misc	\$621,380.88	2,891	\$647,051.21	3,033	\$558,373.72	2,667	\$1,826,805.81	8,591
Guanfacine	\$425,407.42	2,192	\$456,889.95	2,348	\$401,173.02	2,065	\$1,283,470.39	6,605
Atomoxetine	\$130,349.83	628	\$126,694.23	607	\$112,452.24	529	\$369,496.30	1,764
Tetrabenazine	\$38,341.05	6	\$32,864.91	5	\$27,496.12	5	\$98,702.08	16
Memantine	\$11,220.08	51	\$13,662.34	61	\$10,333.76	52	\$35,216.18	164
Sodium Oxybate	\$10,271.42	2	\$11,298.38	2			\$21,569.80	4
Dextromethorphan-quinidine	\$5,473.49	10	\$4,283.59	8	\$6,918.58	16	\$16,675.66	34
Riluzole			\$1,167.44	1			\$1,167.44	1
Acamprosate	\$317.59	2	\$190.37	1			\$507.96	3
Proton-pump Inhibitors	\$697,232.73	6,169	\$745,967.71	6,593	\$373,531.52	3,044	\$1,816,731.96	15,806
Lansoprazole	\$225,080.69	1,076	\$240,624.30	1,135	\$173,835.24	777	\$639,540.23	2,988
Omeprazole	\$242,188.12	3,693	\$256,433.75	3,945	\$112,118.15	1,734	\$610,740.02	9,372
Dexlansoprazole	\$194,825.65	1,283	\$208,263.60	1,371	\$69,876.69	461	\$472,965.94	3,115
Amoxicillin/clarithromycin/lansoprazole	\$23,952.47	49	\$24,429.44	48	\$7,830.85	16	\$56,212.76	113

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Amount Paid*†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Esomeprazole	\$8,689.32	42	\$12,716.55	56	\$8,933.41	41	\$30,339.28	139
Pantoprazole	\$1,959.01	24	\$2,404.12	34	\$937.18	15	\$5,300.31	73
Rabeprazole	\$279.24	1	\$837.72	3			\$1,116.96	4
Omeprazole-sodium Bicarbonate	\$258.23	1	\$258.23	1			\$516.46	2
Macrolides	\$475,616.23	14,638	\$562,151.03	17,473	\$534,250.72	15,888	\$1,572,017.98	47,999
Azithromycin	\$418,263.73	13,609	\$499,815.41	16,396	\$481,156.81	15,030	\$1,399,235.95	45,035
Clarithromycin	\$51,403.95	945	\$55,280.44	985	\$49,251.70	805	\$155,936.09	2,735
Erythromycin	\$8,515.03	59	\$8,641.26	69	\$5,971.92	53	\$23,128.21	181
Erythromycin-sulfisoxazole	\$1,066.46	31	\$917.32	26	\$839.63	23	\$2,823.41	80

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**Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Amount Paid*†**

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Budesonide	\$1,685,231.68	4,078	\$1,683,322.26	4,080	\$1,555,962.34	3,698	\$4,924,516.28	11,856
Pulmicort Respules	\$1,624,408.16	3,852	\$1,633,936.92	3,886	\$1,517,214.16	3,560	\$4,775,559.24	11,298
Budesonide	\$38,142.80	74	\$28,044.74	52	\$26,404.36	52	\$92,591.90	178
Pulmicort Flexhaler	\$22,680.72	152	\$21,340.60	142	\$12,343.82	86	\$56,365.14	380
Aripiprazole	\$1,024,085.81	1,549	\$1,071,075.57	1,660	\$769,931.94	1,182	\$2,865,093.32	4,391
Abilify	\$1,020,511.15	1,545	\$1,066,049.03	1,654	\$765,631.34	1,177	\$2,852,191.52	4,376
Abilify Discmelt	\$3,574.66	4	\$5,026.54	6	\$4,300.60	5	\$12,901.80	15
Oseltamivir	\$43,838.99	254	\$538,088.07	3,085	\$1,923,398.72	11,075	\$2,505,325.78	14,414
Tamiflu	\$43,838.99	254	\$538,088.07	3,085	\$1,923,398.72	11,075	\$2,505,325.78	14,414
Tamiflu	\$16,675.27	149	\$188,505.11	1,682	\$514,092.40	4,597	\$719,272.78	6,428
Amphetamine-dextroamphetamine	\$765,489.66	4,518	\$791,611.75	4,712	\$661,116.40	3,857	\$2,218,217.81	13,087
Adderall Xr	\$640,346.14	2,710	\$659,850.42	2,768	\$558,571.05	2,363	\$1,858,767.61	7,841
Amphetamine-dextroamphetamine	\$96,406.40	1,612	\$103,856.45	1,749	\$75,197.66	1,303	\$275,460.51	4,664
Amphetamine-dextroamphetamine Er	\$28,550.35	195	\$27,718.11	194	\$27,347.69	191	\$83,616.15	580
Montelukast	\$870,321.46	5,190	\$720,869.19	4,293	\$635,960.30	3,780	\$2,146,066.83	12,793
Singulair	\$866,900.90	5,160	\$717,736.38	4,266	\$551,669.24	3,284	\$2,136,306.52	12,710
Singulair	\$542,522.88	3,218	\$696,414.90	4,134	\$635,960.30	3,780	\$1,874,898.08	11,132

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Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Amount Paid*†

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Montelukast Sodium	\$3,420.56	30	\$3,132.81	27	\$3,206.94	26	\$9,760.31	83
Methylphenidate	\$698,747.98	4,067	\$723,669.76	4,236	\$631,636.82	3,691	\$2,054,054.56	11,994
Methylphenidate Hydrochloride Er	\$557,043.52	2,997	\$585,018.39	3,152	\$519,297.00	2,789	\$1,661,358.91	8,938
Metadate Cd	\$58,886.59	296	\$62,512.83	314	\$50,531.92	250	\$171,931.34	860
Daytrana	\$48,749.06	258	\$44,072.18	233	\$38,644.60	202	\$131,465.84	693
Concerta	\$20,634.00	89	\$13,451.78	58	\$9,077.33	38	\$43,163.11	185
Methylphenidate Hydrochloride	\$8,903.44	389	\$10,258.36	424	\$9,146.56	381	\$28,308.36	1,194
Methylin	\$3,393.25	21	\$6,765.96	31	\$3,949.20	16	\$14,108.41	68
Ritalin La	\$612.60	3	\$1,054.78	6	\$605.17	3	\$2,272.55	12
Methylphenidate Hydrochloride Sr	\$480.23	13	\$509.50	17	\$385.04	12	\$1,374.77	42
Lisdexamfetamine	\$663,897.64	3,985	\$681,136.93	4,090	\$594,188.61	3,573	\$1,939,223.18	11,648
Vyvanse	\$663,897.64	3,985	\$681,136.93	4,090	\$594,188.61	3,573	\$1,939,223.18	11,648
Quetiapine	\$637,607.98	1,557	\$671,549.70	1,648	\$368,560.43	1,018	\$1,677,718.11	4,223
Quetiapine Fumarate	\$345,974.08	924	\$372,629.52	975	\$190,423.03	591	\$909,026.63	2,490
Seroquel Xr	\$151,255.31	303	\$165,142.25	331	\$74,504.96	156	\$390,902.52	790
Seroquel	\$140,378.59	330	\$133,777.93	342	\$103,632.44	271	\$377,788.96	943
Antihemophilic Factor	\$553,952.91	13	\$380,835.41	13	\$595,921.73	19	\$1,530,710.05	45
Advate Rahf-pfm	\$414,155.16	7	\$246,593.84	6	\$376,726.22	5	\$1,037,475.22	18
Recombinate	\$17,731.00	2	\$71,640.59	4	\$123,860.16	10	\$213,231.75	16
Helixate Fs	\$57,679.72	2			\$57,529.72	1	\$115,209.44	3

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Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Amount Paid*†

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Xyntha	\$42,893.00	1	\$40,023.99	1	\$37,805.63	3	\$82,916.99	2
Hemofil-m	\$21,494.03	1					\$59,299.66	4
Kogenate Fs With Bioset			\$22,576.99	2			\$22,576.99	2
Mometasone Nasal	\$542,463.60	4,088	\$546,267.70	4,136	\$417,069.22	3,141	\$1,505,800.52	11,365
Nasonex	\$542,463.60	4,088	\$546,267.70	4,136	\$417,069.22	3,141	\$1,505,800.52	11,365
Albuterol	\$501,860.22	12,528	\$532,414.41	13,542	\$403,303.35	10,522	\$1,437,577.98	36,592
Albuterol Sulfate	\$228,814.59	6,771	\$256,811.59	7,633	\$212,387.70	6,495	\$698,013.88	20,899
Ventolin Hfa	\$217,826.19	4,701	\$218,659.26	4,796	\$152,884.18	3,298	\$589,369.63	12,795
Proair Hfa	\$39,564.63	764	\$40,319.04	797	\$4,787.79	96	\$84,671.46	1,657
Proair Hfa	\$48.26	1	\$40,319.04	797	\$25,136.08	490	\$65,503.38	1,288
Proventil Hfa	\$15,476.47	273	\$16,365.42	290	\$12,696.31	217	\$44,538.20	780
Albuterol	\$178.34	19	\$223.00	25	\$199.08	22	\$600.42	66
Azithromycin	\$418,263.73	13,609	\$499,815.41	16,396	\$481,156.81	15,030	\$1,399,235.95	45,035
Azithromycin	\$342,342.03	10,274	\$399,856.70	11,995	\$407,430.02	11,874	\$1,149,628.75	34,143
Azithromycin 5 Day Dose Pack	\$71,445.89	3,151	\$93,690.35	4,150	\$70,477.40	3,029	\$235,613.64	10,330
Azithromycin 3 Day Dose Pack	\$4,475.81	184	\$6,268.36	251	\$3,249.39	127	\$13,993.56	562
Guanfacine	\$425,407.42	2,192	\$456,889.95	2,348	\$401,173.02	2,065	\$1,283,470.39	6,605
Intuniv	\$425,407.42	2,192	\$456,889.95	2,348	\$401,173.02	2,065	\$1,283,470.39	6,605
Guanfacine Hydrochloride	\$12,858.15	896	\$12,058.84	863	\$11,671.33	811	\$36,588.32	2,570
Palivizumab	\$515,788.35	233	\$401,652.99	208	\$313,347.74	166	\$1,230,789.08	607

Note: Resource Utilization Report Currently Contains Only Fee For Service Medicaid Claims

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† Molecule names accounting for less than \$500 in quarterly amount paid are not shown

Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Amount Paid*†

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Synagis	\$515,788.35	233	\$401,652.99	208	\$313,347.74	166	\$1,230,789.08	607
Cefdinir	\$368,174.34	4,711	\$427,161.19	5,461	\$394,606.14	4,929	\$1,189,941.67	15,101
Cefdinir	\$368,174.34	4,711	\$427,161.19	5,461	\$394,606.14	4,929	\$1,189,941.67	15,101
Cetirizine	\$364,508.81	14,962	\$355,922.34	14,944	\$296,757.98	12,140	\$1,017,189.13	42,046
Cetirizine Hydrochloride	\$362,210.33	14,713	\$353,713.58	14,685	\$295,698.06	12,013	\$1,011,621.97	41,411
All Day Allergy	\$1,789.35	215	\$1,696.70	221	\$650.54	95	\$4,136.59	531
All Day Allergy Children's	\$509.13	34	\$512.06	38	\$409.38	32	\$1,430.57	104
All Day Allergy Children's	\$509.13	34	\$12.56	1	\$10.83	1	\$532.52	36
Somatropin	\$333,834.84	94	\$391,551.94	114	\$263,547.79	77	\$988,934.57	285
Nutropin Aq Nuspin 20	\$80,804.75	13	\$118,833.96	20	\$72,875.87	14	\$272,514.58	47
Genotropin	\$72,176.98	17	\$100,966.08	26	\$82,148.20	20	\$255,291.26	63
Nutropin Aq Nuspin 10	\$63,422.03	22	\$69,771.27	26	\$51,732.99	19	\$184,926.29	67
Genotropin Miniquick	\$26,512.45	10	\$31,911.74	14	\$23,076.79	9	\$81,500.98	33
Norditropin Flexpro Pen	\$15,500.79	8	\$23,418.04	10	\$16,918.04	6	\$55,836.87	24
Nutropin Aq Pen 20 Cartridge	\$26,937.52	5	\$9,508.28	2	\$3,170.73	1	\$39,616.53	8
Nutropin Aq Pen 10 Cartridge	\$16,662.71	11	\$11,109.08	8	\$5,046.98	3	\$32,818.77	22
Saizen	\$17,715.60	2	\$8,857.80	1			\$26,573.40	3
Nutropin Aq Nuspin 5	\$6,738.18	3	\$3,964.23	3	\$5,549.72	2	\$16,252.13	8
Tev-tropin	\$5,160.18	1	\$10,320.36	2			\$15,480.54	3
Omnitrope Pen 10 Cartridge	\$2,203.65	2	\$2,891.10	2	\$3,028.47	3	\$8,123.22	7

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† Molecule names accounting for less than \$500 in quarterly amount paid are not shown

Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Amount Paid*†

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Anti-inhibitor Coagulant Complex	\$85,452.60	2	\$611,914.03	8	\$271,341.61	3	\$968,708.24	13
Feiba Nf	\$85,452.60	2	\$470,905.26	7	\$271,341.61	3	\$827,699.47	12
Feiba Vh Immuno			\$141,008.77	1			\$141,008.77	1
Dexmethylphenidate	\$320,323.73	2,024	\$327,838.60	2,098	\$307,223.67	1,847	\$955,386.00	5,969
Focalin Xr	\$305,562.81	1,650	\$312,236.71	1,692	\$17,887.34	87	\$635,686.86	3,429
Focalin Xr	\$17,498.43	91	\$16,748.68	86	\$292,294.33	1,477	\$326,541.44	1,654
Dexmethylphenidate Hydrochloride	\$13,962.12	358	\$14,768.25	388	\$14,114.08	356	\$42,844.45	1,102
Focalin	\$798.80	16	\$833.64	18	\$815.26	14	\$2,447.70	48
Risperidone	\$325,144.89	2,898	\$341,353.10	3,101	\$216,719.23	2,386	\$883,217.22	8,385
Risperidone	\$268,980.14	2,832	\$290,781.36	3,044	\$211,935.60	2,379	\$771,697.10	8,255
Risperdal Consta	\$56,164.75	66	\$50,571.74	57	\$4,427.97	6	\$111,164.46	129
Fluticasone-salmeterol	\$284,174.52	1,137	\$308,983.53	1,218	\$202,033.66	815	\$795,191.71	3,170
Advair Diskus	\$252,532.56	1,020	\$281,055.26	1,118	\$180,665.33	737	\$714,253.15	2,875
Advair Hfa	\$31,641.96	117	\$27,928.27	100	\$21,368.33	78	\$80,938.56	295
Antihemophilic Factor-von Willebrand	\$378,046.86	7	\$84,343.89	3	\$314,402.79	7	\$776,793.54	17
Alphanate	\$378,046.86	7	\$84,343.89	3	\$314,402.79	7	\$776,793.54	17
Olanzapine	\$278,163.32	496	\$313,106.87	538	\$166,756.16	300	\$758,026.35	1,334
Olanzapine	\$206,098.76	347	\$233,891.67	388	\$115,270.43	207	\$555,260.86	942
Zyprexa	\$61,614.66	79	\$72,871.80	100	\$46,753.01	71	\$181,239.47	250
Zyprexa Zydis	\$10,449.90	70	\$6,343.40	50	\$4,732.72	22	\$21,526.02	142

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Amount Paid*†

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Medroxyprogesterone	\$285,825.15	8,031	\$283,925.91	7,611	\$172,369.02	4,524	\$742,120.08	20,166
Medroxyprogesterone Acetate	\$277,574.40	7,632	\$277,882.95	7,365	\$166,095.99	4,302	\$721,553.34	19,299
Depo-provera Contraceptive	\$7,085.04	387	\$1,754.88	96	\$3,674.28	201	\$12,514.20	684
Depo-provera Contraceptive	\$3,509.76	192	\$4,277.52	234	\$2,467.80	135	\$10,255.08	561
Depo-subq Provera 104	\$1,165.71	12	\$1,113.75	9	\$2,598.75	21	\$4,878.21	42
Depo-provera			\$651.69	3			\$651.69	3
Ondansetron	\$199,487.32	2,373	\$286,360.77	3,115	\$248,737.24	2,447	\$734,585.33	7,935
Ondansetron Hydrochloride	\$199,487.32	2,373	\$286,360.77	3,115	\$248,737.24	2,447	\$734,585.33	7,935

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Number of Claims†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Penicillins	\$410,493.78	20,114	\$486,879.78	23,454	\$432,484.87	19,625	\$1,329,858.43	63,193
Amoxicillin	\$145,251.08	14,239	\$170,073.19	16,630	\$156,462.04	14,239	\$471,786.31	45,108
Amoxicillin-clavulanate	\$245,519.09	4,404	\$298,553.71	5,297	\$265,336.49	4,522	\$636,456.64	11,130
Penicillin V Potassium	\$14,981.59	1,316	\$15,313.46	1,367	\$8,737.98	781	\$39,033.03	3,464
Ampicillin	\$1,252.70	116	\$1,438.18	129	\$795.19	60	\$3,486.07	305
Penicillin G Benzathine	\$872.98	15	\$1,104.89	19	\$837.01	17	\$2,814.88	51
Piperacillin-tazobactam	\$2,200.71	7			\$41.71	1	\$2,242.42	8
Opiate Agonists	\$462,316.22	22,371	\$500,406.48	23,928	\$190,481.89	9,082	\$1,153,204.59	55,381
Acetaminophen-hydrocodone	\$209,871.22	14,316	\$230,765.33	15,429	\$75,036.14	5,097	\$515,672.69	34,842
Acetaminophen-codeine	\$24,125.26	2,927	\$27,113.25	3,270	\$18,558.48	2,233	\$69,796.99	8,430
Acetaminophen-oxycodone	\$62,142.28	2,034	\$67,753.06	2,159	\$19,744.17	591	\$149,639.51	4,784
Tramadol	\$7,507.83	1,407	\$7,212.15	1,373	\$2,414.00	452	\$17,133.98	3,232
Fentanyl	\$79,210.05	341	\$81,073.94	345	\$47,662.13	223	\$207,946.12	909
Morphine	\$33,431.93	296	\$35,800.65	311	\$11,843.46	130	\$81,076.04	737
Hydrocodone-ibuprofen	\$8,120.86	284	\$9,231.60	284	\$3,092.18	103	\$20,444.64	671
Oxycodone	\$25,675.50	267	\$30,788.38	284	\$8,799.73	87	\$65,263.61	638
Acetaminophen-tramadol	\$6,169.88	229	\$5,901.51	212	\$1,585.44	57	\$13,656.83	498
Hydromorphone	\$2,816.99	88	\$1,922.10	89	\$1,012.13	44	\$5,751.22	221

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Number of Claims†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Meperidine	\$640.81	73	\$731.88	78	\$335.57	35	\$1,383.98	152
Methadone	\$530.08	65	\$486.14	61	\$159.25	22	\$1,175.47	148
Apap/cafeine/dihydrocodeine	\$1,500.11	25	\$1,307.07	21	\$45.37	1	\$2,852.55	47
Aspirin-oxycodone	\$282.01	12	\$189.10	9	\$63.30	2	\$525.62	22
Oxymorphone	\$1,633.40	4	\$816.70	2	\$1,314.80	3	\$3,764.90	9
Tapentadol	\$790.18	2	\$919.27	3	\$504.90	2	\$2,214.35	7
Second Generation Antihistamines	\$395,050.69	17,862	\$386,965.76	17,886	\$319,763.96	14,360	\$1,101,780.41	50,108
Cetirizine	\$364,508.81	14,962	\$355,922.34	14,944	\$296,757.98	12,140	\$1,017,189.13	42,046
Loratadine	\$15,575.16	2,183	\$14,049.20	2,098	\$12,344.42	1,708	\$41,968.78	5,989
Cetirizine-pseudoephedrine	\$9,499.24	515	\$11,794.24	627	\$7,638.31	391	\$28,931.79	1,533
Loratadine-pseudoephedrine	\$2,436.05	160	\$2,724.36	185	\$1,554.67	105	\$6,715.08	450
Levocetirizine	\$2,517.57	34	\$2,523.49	33	\$1,567.55	19	\$6,238.14	79
Acrivastine-pseudoephedrine	\$653.14	7	\$1,369.37	12	\$378.18	4	\$2,400.69	23
Desloratadine	\$163.59	1	\$289.60	2	\$289.60	2	\$742.79	5
Macrolides	\$475,616.23	14,638	\$562,151.03	17,473	\$534,250.72	15,888	\$1,572,017.98	47,999
Azithromycin	\$418,263.73	13,609	\$499,815.41	16,396	\$481,156.81	15,030	\$1,399,235.95	45,035
Clarithromycin	\$51,403.95	945	\$55,280.44	985	\$49,251.70	805	\$155,936.09	2,735
Erythromycin	\$8,515.03	59	\$8,641.26	69	\$5,971.92	53	\$23,128.21	181
Erythromycin-sulfisoxazole	\$1,066.46	31	\$917.32	26	\$839.63	23	\$2,823.41	80
Adrenals	\$2,070,975.22	16,161	\$2,071,801.60	17,171	\$1,868,312.27	14,272	\$6,011,089.09	47,604
Prednisolone	\$123,820.02	7,178	\$132,599.40	8,040	\$121,519.97	7,294	\$377,939.39	22,512

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Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Number of Claims†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Budesonide	\$1,685,231.68	4,078	\$1,683,322.26	4,080	\$1,555,962.34	3,698	\$4,924,516.28	11,856
Prednisone	\$9,607.59	1,808	\$9,512.75	1,876	\$6,868.19	1,232	\$25,988.53	4,916
Methylprednisolone	\$14,107.35	1,148	\$15,478.56	1,264	\$7,930.19	584	\$37,516.10	2,996
Fluticasone	\$74,939.91	511	\$69,570.00	475	\$61,612.45	428	\$206,122.36	1,414
Dexamethasone	\$4,287.14	363	\$3,947.11	391	\$2,878.01	272	\$11,112.26	1,026
Beclomethasone	\$47,023.86	345	\$43,864.97	319	\$34,947.93	252	\$125,836.76	916
Budesonide-formoterol	\$54,985.24	251	\$63,019.90	285	\$33,834.15	152	\$151,839.29	688
Mometasone	\$27,758.12	202	\$26,426.02	190	\$25,474.87	183	\$79,659.01	575
Hydrocortisone	\$1,952.94	83	\$2,508.74	83	\$1,705.23	64	\$6,166.91	230
Formoterol-mometasone	\$23,954.35	111	\$18,457.56	85	\$13,777.43	63	\$42,631.49	198
Fludrocortisone	\$1,556.81	57	\$1,462.38	59	\$1,177.32	39	\$4,196.51	155
Flunisolide Nasal	\$1,689.92	24	\$1,502.32	21	\$624.19	11	\$3,816.43	56
Antitussives	\$101,020.74	12,284	\$125,968.25	15,465	\$150,385.78	18,228	\$377,374.77	45,977
Brompheniramine/dextromethorph/phe	\$67,896.52	7,416	\$82,498.50	8,921	\$103,190.68	11,202	\$253,585.70	27,539
Codeine-guaifenesin	\$13,188.62	2,399	\$18,224.98	3,394	\$22,346.71	3,964	\$53,760.31	9,757
Dextromethorphan-guaifenesin	\$5,483.53	997	\$6,947.74	1,264	\$7,834.53	1,386	\$20,265.80	3,647
Nitrofurantoin	\$69,599.71	1,259	\$66,057.13	1,220	\$36,483.16	490	\$172,140.00	2,969
Benzonatate	\$6,299.27	706	\$8,212.81	984	\$6,094.91	702	\$20,606.99	2,392
Dextromethorphan	\$6,408.62	561	\$7,583.21	637	\$8,188.57	686	\$22,180.40	1,884
Brompheniramine/dextromethorphan/ps	\$746.20	123	\$812.63	128	\$868.83	141	\$2,427.66	392
Codeine/guaifenesin/pse	\$997.98	82	\$1,679.82	136	\$1,861.55	147	\$4,539.35	365

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Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Number of Claims†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Benzodiazepines	\$196,457.13	15,828	\$203,488.99	16,884	\$160,943.77	11,697	\$560,889.89	44,409
Lorazepam	\$48,424.71	7,242	\$50,707.65	7,611	\$40,890.12	5,988	\$140,022.48	20,841
Alprazolam	\$36,960.14	4,576	\$40,361.34	4,990	\$21,337.43	2,761	\$98,658.91	12,327
Diazepam	\$102,105.38	2,890	\$102,341.70	3,076	\$90,477.78	2,008	\$294,924.86	7,974
Temazepam	\$5,791.55	803	\$6,253.61	829	\$5,214.10	666	\$17,259.26	2,298
Clorazepate	\$1,943.50	188	\$2,276.72	216	\$1,897.42	170	\$6,117.64	574
Chlordiazepoxide	\$397.07	47	\$486.29	59	\$293.66	33	\$1,177.02	139
Triazolam	\$374.43	44	\$415.96	55	\$336.45	35	\$1,126.84	134
Oxazepam	\$317.92	11	\$447.34	14	\$353.21	11	\$1,118.47	36
Beta-adrenergic Agonists	\$841,788.88	13,951	\$908,149.66	15,086	\$635,039.80	11,465	\$2,384,978.34	40,502
Albuterol	\$501,860.22	12,528	\$532,414.41	13,542	\$403,303.35	10,522	\$1,437,577.98	36,592
Fluticasone-salmeterol	\$284,174.52	1,137	\$308,983.53	1,218	\$202,033.66	815	\$795,191.71	3,170
Albuterol-ipratropium	\$47,036.82	202	\$52,681.03	227	\$19,960.39	89	\$119,678.24	518
Terbutaline	\$1,587.16	48	\$1,655.06	54	\$225.82	6	\$3,468.04	108
Levalbuterol	\$5,597.67	28	\$9,377.72	32	\$7,790.41	24	\$22,765.80	84
Formoterol	\$931.36	6	\$2,426.64	11	\$1,114.90	7	\$4,472.90	24
Pirbuterol	\$297.28	2	\$450.21	3	\$300.14	2	\$1,047.63	7
Arformoterol	\$601.13	2	\$611.27	2	\$611.27	2	\$1,823.67	6
Nonsteroidal Anti-inflammatory Agent	\$144,722.07	13,607	\$151,604.22	14,145	\$109,576.90	10,682	\$405,903.19	38,434
Ibuprofen	\$58,075.24	6,547	\$62,097.29	6,984	\$74,846.45	7,026	\$195,018.98	20,557
Naproxen	\$39,760.48	2,563	\$40,551.63	2,599	\$14,901.43	1,073	\$95,213.54	6,235

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Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Number of Claims†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Aspirin	\$5,881.72	1,816	\$5,689.12	1,794	\$5,457.82	1,684	\$17,028.66	5,294
Meloxicam	\$10,511.03	1,409	\$11,124.43	1,494	\$4,338.94	505	\$25,974.40	3,408
Apap/butalbital/cafeine	\$20,212.15	937	\$20,980.09	968	\$9,792.70	422	\$50,984.94	2,327
Ketorolac	\$5,218.29	482	\$5,980.05	501	\$1,772.87	138	\$12,971.21	1,121
Diclofenac	\$9,946.10	404	\$10,247.89	404	\$2,892.82	117	\$23,086.81	925
Indomethacin	\$3,029.44	146	\$2,619.58	121	\$1,315.57	57	\$6,964.59	324
Etodolac	\$1,104.27	45	\$1,320.26	52	\$475.46	19	\$2,899.99	116
Sulindac	\$1,121.50	50	\$907.62	40	\$255.19	11	\$2,284.31	101
Celecoxib	\$7,273.16	37	\$7,683.79	42	\$2,262.03	14	\$17,218.98	93
Asa/butalbital/cafeine	\$835.53	29	\$1,105.36	32	\$250.84	9	\$2,191.73	70
Ketoprofen	\$216.70	28	\$445.36	31	\$31.72	3	\$693.78	62
Salsalate	\$265.96	8	\$252.36	6	\$177.29	6	\$695.61	20
Diflunisal	\$128.80	5	\$341.92	6	\$295.74	4	\$766.46	15
Diclofenac-misoprostol	\$395.22	2	\$197.61	1			\$592.83	3
Mefenamic Acid	\$338.47	1	\$393.69	1			\$732.16	2
Cephalosporins	\$759,147.45	10,898	\$846,010.36	11,997	\$778,630.12	9,911	\$2,383,787.93	32,806
Cefdinir	\$368,174.34	4,711	\$427,161.19	5,461	\$394,606.14	4,929	\$1,189,941.67	15,101
Cephalexin	\$46,226.30	2,949	\$46,516.30	3,033	\$34,647.05	1,952	\$127,389.65	7,934
Cefprozil	\$101,401.43	1,731	\$112,595.87	1,878	\$104,587.72	1,715	\$318,585.02	5,324
Cefixime	\$220,123.50	870	\$226,440.74	894	\$224,714.03	833	\$671,278.27	2,597
Cefuroxime	\$8,325.79	391	\$9,419.07	454	\$6,852.80	302	\$24,597.66	1,147
Ceftriaxone	\$7,532.22	124	\$15,596.33	124	\$6,459.98	78	\$29,588.53	326

Note: Resource Utilization Report Currently Contains Only Fee For Service Medicaid Claims

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† Molecule names accounting for less than \$500 in quarterly amount paid are not shown

Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Number of Claims†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Cefadroxil	\$4,263.45	104	\$4,597.26	108	\$3,960.31	83	\$12,821.02	295
Cefepime	\$1,699.99	6	\$2,180.77	24	\$1,409.48	5	\$5,290.24	35
Cefaclor	\$508.50	9	\$489.14	11	\$300.19	6	\$1,297.83	26
Cefazolin	\$28.93	1	\$149.77	4	\$322.96	4	\$501.66	9
Ceftibuten	\$863.00	2	\$577.94	2	\$577.94	2	\$2,018.88	6
Antidepressants	\$411,813.11	11,385	\$439,273.75	12,293	\$163,800.07	5,547	\$1,014,886.93	29,225
Citalopram	\$16,686.77	2,199	\$17,555.87	2,354	\$9,268.35	1,117	\$43,510.99	5,670
Bupropion	\$123,063.48	1,308	\$129,805.68	1,404	\$48,210.80	564	\$301,079.96	3,276
Trazodone	\$10,373.17	1,236	\$11,169.52	1,289	\$4,761.29	582	\$26,303.98	3,107
Sertraline	\$13,539.24	1,712	\$14,929.10	1,899	\$8,931.43	1,051	\$24,089.15	2,977
Fluoxetine	\$17,876.48	1,270	\$18,841.68	1,359	\$8,578.16	697	\$27,523.12	2,060
Amitriptyline	\$4,003.79	743	\$4,305.03	804	\$1,902.76	321	\$10,211.58	1,868
Desvenlafaxine	\$87,143.67	546	\$96,001.02	598	\$20,484.23	130	\$203,628.92	1,274
Paroxetine	\$7,718.33	539	\$7,694.60	540	\$2,621.05	180	\$18,033.98	1,259
Mirtazapine	\$17,567.03	461	\$19,098.77	493	\$8,641.38	230	\$45,307.18	1,184
Doxepin	\$5,236.40	390	\$5,876.64	484	\$1,693.98	132	\$12,807.02	1,006
Imipramine	\$9,385.69	171	\$8,708.72	198	\$8,451.19	149	\$26,545.60	518
Escitalopram	\$19,412.45	182	\$19,464.12	183	\$13,921.06	139	\$52,797.63	504
Duloxetine	\$38,626.74	157	\$41,800.48	174	\$11,634.13	53	\$92,061.35	384
Venlafaxine	\$21,384.09	148	\$22,050.91	161	\$5,690.98	47	\$49,125.98	356
Nortriptyline	\$1,079.48	132	\$1,086.91	129	\$514.61	58	\$2,681.00	319
Fluvoxamine	\$8,975.50	68	\$9,361.29	83	\$3,636.83	44	\$21,973.62	195

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Number of Claims†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Amitriptyline-perphenazine	\$3,477.63	53	\$3,446.96	61	\$586.64	11	\$7,511.23	125
Clomipramine	\$1,022.00	30	\$1,172.55	37	\$821.65	26	\$3,016.20	93
Amitriptyline-chlordiazepoxide	\$2,030.50	30	\$2,054.92	31	\$630.60	10	\$4,716.02	71
Fluoxetine-olanzapine	\$3,092.65	6	\$4,713.44	8	\$2,786.96	5	\$10,593.05	19
Anticonvulsants, Miscellaneous	\$973,197.39	10,305	\$1,064,197.64	11,084	\$658,467.59	6,450	\$2,695,862.62	27,839
Gabapentin	\$94,255.02	2,542	\$106,521.22	2,844	\$38,819.33	1,068	\$239,595.57	6,454
Divalproex Sodium	\$163,725.04	1,604	\$173,491.74	1,703	\$110,031.89	1,126	\$447,248.67	4,433
Levetiracetam	\$108,363.09	1,270	\$117,102.95	1,367	\$88,044.29	1,004	\$313,510.33	3,641
Topiramate	\$59,561.72	1,129	\$63,566.48	1,189	\$39,083.26	671	\$162,211.46	2,989
Oxcarbazepine	\$132,610.10	1,017	\$139,091.52	1,057	\$109,939.76	839	\$381,641.38	2,913
Lamotrigine	\$72,239.77	857	\$79,294.12	915	\$54,055.74	579	\$205,589.63	2,351
Pregabalin	\$141,614.58	643	\$152,512.29	695	\$52,316.41	244	\$346,443.28	1,582
Carbamazepine	\$32,402.06	583	\$33,077.90	608	\$19,852.54	379	\$85,332.50	1,570
Zonisamide	\$12,467.72	268	\$11,773.36	278	\$9,409.32	210	\$33,650.40	756
Valproic Acid	\$8,090.57	168	\$8,632.74	179	\$6,979.20	154	\$23,702.51	501
Lacosamide	\$65,538.76	150	\$73,785.09	165	\$52,017.61	116	\$191,341.46	431
Rufinamide	\$27,911.46	35	\$31,835.98	39	\$25,239.93	31	\$84,987.37	105
Felbamate	\$21,674.36	25	\$21,887.54	27	\$16,723.36	20	\$60,285.26	72
Tiagabine	\$7,008.21	8	\$8,029.79	10	\$5,231.40	5	\$20,269.40	23
Vigabatrin	\$25,734.93	6	\$43,594.92	8	\$30,723.55	4	\$100,053.40	18
Sulfonamides	\$141,435.86	10,961	\$131,424.44	10,274	\$92,194.68	6,601	\$365,054.98	27,836

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Number of Claims†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Sulfamethoxazole-trimethoprim	\$139,642.44	10,914	\$130,399.04	10,224	\$90,902.48	6,570	\$360,943.96	27,708
Sulfasalazine	\$1,122.04	46	\$1,025.40	50	\$620.82	30	\$2,768.26	126
Sulfadiazine	\$671.38	1			\$671.38	1	\$1,342.76	2
Amphetamines	\$1,455,935.85	8,656	\$1,501,148.29	8,964	\$1,280,498.47	7,575	\$4,237,582.61	25,195
Amphetamine-dextroamphetamine	\$765,489.66	4,518	\$791,611.75	4,712	\$661,116.40	3,857	\$2,218,217.81	13,087
Lisdexamfetamine	\$663,897.64	3,985	\$681,136.93	4,090	\$594,188.61	3,573	\$1,939,223.18	11,648
Dextroamphetamine	\$26,548.55	153	\$28,399.61	162	\$25,193.46	145	\$80,141.62	460
Antipsychotics (atypical And Typical)	\$2,737,912.28	8,233	\$2,892,319.71	8,831	\$1,704,511.72	5,817	\$7,334,743.71	22,881
Risperidone	\$325,144.89	2,898	\$341,353.10	3,101	\$216,719.23	2,386	\$883,217.22	8,385
Aripiprazole	\$1,024,085.81	1,549	\$1,071,075.57	1,660	\$769,931.94	1,182	\$2,865,093.32	4,391
Quetiapine	\$637,607.98	1,557	\$671,549.70	1,648	\$368,560.43	1,018	\$1,677,718.11	4,223
Olanzapine	\$278,163.32	496	\$313,106.87	538	\$166,756.16	300	\$758,026.35	1,334
Haloperidol	\$22,650.97	482	\$26,576.46	554	\$10,485.35	255	\$59,712.78	1,291
Ziprasidone	\$89,912.19	233	\$98,430.85	259	\$41,807.31	103	\$224,856.95	595
Chlorpromazine	\$24,765.32	232	\$24,585.08	224	\$18,618.68	180	\$44,933.94	434
Asenapine	\$75,894.09	146	\$83,860.03	169	\$42,843.12	82	\$202,597.24	397
Paliperidone	\$189,571.68	167	\$179,805.40	161	\$28,381.49	37	\$397,758.57	365
Clozapine	\$20,417.43	127	\$20,459.49	138	\$9,111.26	69	\$49,988.18	334
Prochlorperazine	\$2,215.88	116	\$2,113.12	126	\$648.20	40	\$4,977.20	282
Lurasidone	\$65,793.04	104	\$72,754.26	119	\$19,944.27	33	\$158,491.57	256
Perphenazine	\$5,073.94	70	\$4,840.76	72	\$3,150.44	48	\$13,065.14	190

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Class Report
Top 15 Classes By Quarterly Number of Claims†

AHFS Class / Generic Molecule	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Fluphenazine	\$2,701.33	58	\$2,745.97	60	\$595.00	20	\$6,042.30	138
Thioridazine	\$999.83	37	\$1,256.45	44	\$1,087.18	33	\$3,343.46	114
Trifluoperazine	\$1,289.04	28	\$1,103.09	23	\$621.74	13	\$3,013.87	64
Thiothixene	\$503.84	20	\$621.29	25	\$279.38	11	\$1,404.51	56
Iloperidone	\$11,458.90	20	\$13,135.65	23	\$4,026.12	6	\$28,620.67	49
Loxapine	\$909.26	11	\$1,436.64	18	\$563.54	6	\$2,909.44	35
Pimozide	\$658.28	6	\$744.88	6	\$380.88	4	\$1,784.04	16

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

**Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Number of Claims†**

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Amoxicillin	\$145,251.08	14,239	\$170,073.19	16,630	\$156,462.04	14,239	\$471,786.31	45,108
Amoxicillin	\$144,780.44	14,236	\$169,136.73	16,626	\$156,146.28	14,237	\$470,063.45	45,099
Moxatag	\$470.64	3	\$936.46	4	\$315.76	2	\$1,722.86	9
Azithromycin	\$418,263.73	13,609	\$499,815.41	16,396	\$481,156.81	15,030	\$1,399,235.95	45,035
Azithromycin	\$342,342.03	10,274	\$399,856.70	11,995	\$407,430.02	11,874	\$1,149,628.75	34,143
Azithromycin 5 Day Dose Pack	\$71,445.89	3,151	\$93,690.35	4,150	\$70,477.40	3,029	\$235,613.64	10,330
Azithromycin 3 Day Dose Pack	\$4,475.81	184	\$6,268.36	251	\$3,249.39	127	\$13,993.56	562
Cetirizine	\$364,508.81	14,962	\$355,922.34	14,944	\$296,757.98	12,140	\$1,017,189.13	42,046
Cetirizine Hydrochloride	\$362,210.33	14,713	\$353,713.58	14,685	\$295,698.06	12,013	\$1,011,621.97	41,411
All Day Allergy	\$1,789.35	215	\$1,696.70	221	\$650.54	95	\$4,136.59	531
All Day Allergy Children's	\$509.13	34	\$512.06	38	\$409.38	32	\$1,430.57	104
All Day Allergy Children's	\$509.13	34	\$12.56	1	\$10.83	1	\$532.52	36
Albuterol	\$501,860.22	12,528	\$532,414.41	13,542	\$403,303.35	10,522	\$1,437,577.98	36,592
Albuterol Sulfate	\$228,814.59	6,771	\$256,811.59	7,633	\$212,387.70	6,495	\$698,013.88	20,899
Ventolin Hfa	\$217,826.19	4,701	\$218,659.26	4,796	\$152,884.18	3,298	\$589,369.63	12,795
Proair Hfa	\$39,564.63	764	\$40,319.04	797	\$4,787.79	96	\$84,671.46	1,657
Proair Hfa	\$48.26	1	\$40,319.04	797	\$25,136.08	490	\$65,503.38	1,288

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Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Number of Claims†

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Proventil Hfa	\$15,476.47	273	\$16,365.42	290	\$12,696.31	217	\$44,538.20	780
Albuterol	\$178.34	19	\$223.00	25	\$199.08	22	\$600.42	66
Acetaminophen-hydrocodone	\$209,871.22	14,316	\$230,765.33	15,429	\$75,036.14	5,097	\$515,672.69	34,842
Acetaminophen-hydrocodone Bitartrate	\$1,590.60	90	\$230,730.35	15,423	\$75,033.29	5,096	\$307,354.24	20,609
Acetaminophen-hydrocodone Bitartrate	\$209,860.96	14,314	\$1,903.83	122	\$1,322.69	60	\$213,087.48	14,496
Sulfamethoxazole-trimethoprim	\$139,642.44	10,914	\$130,399.04	10,224	\$90,902.48	6,570	\$360,943.96	27,708
Sulfamethoxazole-trimethoprim	\$96,150.74	6,086	\$88,260.94	5,574	\$69,796.64	4,382	\$254,208.32	16,042
Sulfamethoxazole-trimethoprim Ds	\$42,527.44	4,726	\$40,854.68	4,512	\$20,693.40	2,138	\$104,075.52	11,376
Smz-tmp Ds	\$964.26	102	\$1,283.42	138	\$412.44	50	\$2,660.12	290
Brompheniramine/dextromethorph/p	\$67,896.52	7,416	\$82,498.50	8,921	\$103,190.68	11,202	\$253,585.70	27,539
Rynex Dm	\$65,731.57	7,103	\$80,922.51	8,710	\$100,857.53	10,890	\$247,511.61	26,703
Endacof-dm	\$3,614.15	410	\$5,933.21	656	\$6,332.59	716	\$15,879.95	1,782
Cold & Cough Childrens	\$867.01	104	\$922.32	113	\$1,556.23	189	\$3,345.56	406
Dimaphen Dm	\$1,173.71	192	\$478.88	76	\$705.44	112	\$2,358.03	380
Prednisolone	\$123,820.02	7,178	\$132,599.40	8,040	\$121,519.97	7,294	\$377,939.39	22,512
Prednisolone Sodium Phosphate	\$34,863.56	2,712	\$39,243.70	3,102	\$37,005.47	2,810	\$111,112.73	8,624
Prednisolone	\$22,089.22	2,609	\$25,728.84	3,059	\$23,747.36	2,756	\$71,565.42	8,424
Veripred 20	\$47,001.98	1,603	\$46,411.38	1,609	\$44,188.58	1,543	\$137,601.94	4,755
Orapred Odt	\$19,041.86	215	\$20,354.85	230	\$15,670.49	164	\$55,067.20	609
Millipred	\$797.91	38	\$784.16	37	\$305.50	17	\$1,887.57	92

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Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Number of Claims†

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Flo-pred					\$551.59	2	\$551.59	2
Clonazepam	\$63,104.04	8,188	\$65,165.08	8,524	\$45,991.08	5,628	\$174,260.20	22,340
Clonazepam	\$63,104.04	8,188	\$65,165.08	8,524	\$45,991.08	5,628	\$174,260.20	22,340
Lorazepam	\$48,424.71	7,242	\$50,707.65	7,611	\$40,890.12	5,988	\$140,022.48	20,841
Lorazepam	\$48,424.71	7,242	\$50,707.65	7,611	\$40,890.12	5,988	\$140,022.48	20,841
Ibuprofen	\$58,075.24	6,547	\$62,097.29	6,984	\$74,846.45	7,026	\$195,018.98	20,557
Ibuprofen	\$49,151.56	5,067	\$52,965.62	5,465	\$67,907.17	5,985	\$170,024.35	16,517
Ibu	\$7,352.08	1,300	\$7,335.64	1,320	\$4,629.51	782	\$19,317.23	3,402
Ibuprofen Children's	\$1,265.33	143	\$1,340.47	148	\$1,722.70	192	\$4,328.50	483
Childrens Ibuprofen	\$292.29	35	\$455.56	51	\$575.45	66	\$1,323.30	152
Medroxyprogesterone	\$285,825.15	8,031	\$283,925.91	7,611	\$172,369.02	4,524	\$742,120.08	20,166
Medroxyprogesterone Acetate	\$277,574.40	7,632	\$277,882.95	7,365	\$166,095.99	4,302	\$721,553.34	19,299
Depo-provera Contraceptive	\$7,085.04	387	\$1,754.88	96	\$3,674.28	201	\$12,514.20	684
Depo-provera Contraceptive	\$3,509.76	192	\$4,277.52	234	\$2,467.80	135	\$10,255.08	561
Depo-subq Provera 104	\$1,165.71	12	\$1,113.75	9	\$2,598.75	21	\$4,878.21	42
Depo-provera			\$651.69	3			\$651.69	3
Promethazine	\$69,610.16	6,000	\$81,313.94	7,064	\$54,139.12	5,030	\$205,063.22	18,094
Promethazine Hydrochloride	\$62,143.10	5,542	\$70,797.88	6,422	\$2,674.28	200	\$135,615.26	12,164
Promethazine Hydrochloride	\$6,513.48	462	\$6,795.76	480	\$46,921.06	4,540	\$60,230.30	5,482
Phenadoz	\$3,516.30	254	\$5,977.20	458	\$4,300.88	352	\$13,794.38	1,064

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Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Number of Claims†

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Promethegan	\$3,891.52	198	\$4,538.86	184	\$2,917.18	138	\$11,347.56	520
Diphenhydramine	\$30,510.24	6,340	\$29,484.60	6,212	\$22,791.68	4,652	\$82,786.52	17,204
Q-dryl	\$19,030.36	3,844	\$18,133.72	3,692	\$13,584.92	2,740	\$50,749.00	10,276
Diphenhydramine Hydrochloride	\$5,525.12	1,300	\$5,868.40	1,380	\$5,116.52	1,080	\$16,510.04	3,760
Diphenhist	\$3,273.84	620	\$2,953.76	596	\$1,748.64	324	\$7,976.24	1,540
Banophen	\$1,917.52	436	\$1,642.44	376	\$1,857.84	428	\$5,417.80	1,240
Diphenhydramine Hydrochloride	\$22.20	4	\$28.80	4	\$5,116.52	1,080	\$5,167.52	1,088
Good Neighbor Pharmacy Childrens Aller	\$194.16	36	\$380.76	72	\$42.76	8	\$617.68	116
Child Allergy	\$141.40	24	\$218.64	44	\$140.16	24	\$500.20	92
Cefdinir	\$368,174.34	4,711	\$427,161.19	5,461	\$394,606.14	4,929	\$1,189,941.67	15,101
Cefdinir	\$368,174.34	4,711	\$427,161.19	5,461	\$394,606.14	4,929	\$1,189,941.67	15,101
Oseltamivir	\$43,838.99	254	\$538,088.07	3,085	\$1,923,398.72	11,075	\$2,505,325.78	14,414
Tamiflu	\$43,838.99	254	\$538,088.07	3,085	\$1,923,398.72	11,075	\$2,505,325.78	14,414
Tamiflu	\$16,675.27	149	\$188,505.11	1,682	\$514,092.40	4,597	\$719,272.78	6,428
Amphetamine-dextroamphetamine	\$765,489.66	4,518	\$791,611.75	4,712	\$661,116.40	3,857	\$2,218,217.81	13,087
Adderall Xr	\$640,346.14	2,710	\$659,850.42	2,768	\$558,571.05	2,363	\$1,858,767.61	7,841
Amphetamine-dextroamphetamine	\$96,406.40	1,612	\$103,856.45	1,749	\$75,197.66	1,303	\$275,460.51	4,664
Amphetamine-dextroamphetamine Er	\$28,550.35	195	\$27,718.11	194	\$27,347.69	191	\$83,616.15	580
Montelukast	\$870,321.46	5,190	\$720,869.19	4,293	\$635,960.30	3,780	\$2,146,066.83	12,793
Singulair	\$866,900.90	5,160	\$717,736.38	4,266	\$551,669.24	3,284	\$2,136,306.52	12,710

Note: Resource Utilization Report Currently Contains Only Fee For Service Medicaid Claims

* Dollar figures represent reimbursement to pharmacies and are not representative of overall Medicaid costs.

† Molecule names accounting for less than \$500 in quarterly amount paid are not shown

Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Number of Claims†

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Singular	\$542,522.88	3,218	\$696,414.90	4,134	\$635,960.30	3,780	\$1,874,898.08	11,132
Montelukast Sodium	\$3,420.56	30	\$3,132.81	27	\$3,206.94	26	\$9,760.31	83
Hydroxyzine	\$83,685.90	4,898	\$79,234.10	4,680	\$46,101.40	2,766	\$209,021.40	12,344
Hydroxyzine Hydrochloride	\$67,656.78	3,272	\$62,839.40	3,052	\$38,788.92	2,030	\$169,285.10	8,354
Hydroxyzine Pamoate	\$16,029.12	1,626	\$16,394.70	1,628	\$7,312.48	736	\$39,736.30	3,990
Hydroxyzine Hydrochloride	\$67,656.78	3,272	\$143.80	2	\$48.10	2	\$67,848.68	3,276
Alprazolam	\$36,960.14	4,576	\$40,361.34	4,990	\$21,337.43	2,761	\$98,658.91	12,327
Alprazolam	\$32,659.60	4,524	\$35,354.22	4,930	\$19,230.90	2,737	\$87,244.72	12,191
Alprazolam Er	\$4,300.54	52	\$5,007.12	60	\$2,106.53	24	\$11,414.19	136
Methylphenidate	\$698,747.98	4,067	\$723,669.76	4,236	\$631,636.82	3,691	\$2,054,054.56	11,994
Methylphenidate Hydrochloride Er	\$557,043.52	2,997	\$585,018.39	3,152	\$519,297.00	2,789	\$1,661,358.91	8,938
Methylphenidate Hydrochloride	\$8,903.44	389	\$10,258.36	424	\$9,146.56	381	\$28,308.36	1,194
Metadate Cd	\$58,886.59	296	\$62,512.83	314	\$50,531.92	250	\$171,931.34	860
Daytrana	\$48,749.06	258	\$44,072.18	233	\$38,644.60	202	\$131,465.84	693
Concerta	\$20,634.00	89	\$13,451.78	58	\$9,077.33	38	\$43,163.11	185
Methylin	\$3,393.25	21	\$6,765.96	31	\$3,949.20	16	\$14,108.41	68
Methylphenidate Hydrochloride Sr	\$480.23	13	\$509.50	17	\$385.04	12	\$1,374.77	42
Ritalin La	\$612.60	3	\$1,054.78	6	\$605.17	3	\$2,272.55	12
Budesonide	\$1,685,231.68	4,078	\$1,683,322.26	4,080	\$1,555,962.34	3,698	\$4,924,516.28	11,856
Pulmicort Respules	\$1,624,408.16	3,852	\$1,633,936.92	3,886	\$1,517,214.16	3,560	\$4,775,559.24	11,298

Note: Resource Utilization Report Currently Contains Only Fee For Service Medicaid Claims

* Dollar figures represent reimbursement to pharmacies and are not representative of overall Medicaid costs.

† Molecule names accounting for less than \$500 in quarterly amount paid are not shown

Prepared by the Evidence-Based DUR Initiative, MS-DUR

Resource Utilization Report
Drug Detail Report
Top 25 Drugs By Quarterly Number of Claims†

Generic Molecule / Drug Name	October 2012		November 2012		December 2012		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Pulmicort Flexhaler	\$22,680.72	152	\$21,340.60	142	\$12,343.82	86	\$56,365.14	380
Budesonide	\$38,142.80	74	\$28,044.74	52	\$26,404.36	52	\$92,591.90	178
Lisdexamfetamine	\$663,897.64	3,985	\$681,136.93	4,090	\$594,188.61	3,573	\$1,939,223.18	11,648
Vyvanse	\$663,897.64	3,985	\$681,136.93	4,090	\$594,188.61	3,573	\$1,939,223.18	11,648
Mometasone Nasal	\$542,463.60	4,088	\$546,267.70	4,136	\$417,069.22	3,141	\$1,505,800.52	11,365
Nasonex	\$542,463.60	4,088	\$546,267.70	4,136	\$417,069.22	3,141	\$1,505,800.52	11,365
Amoxicillin-clavulanate	\$245,519.09	4,404	\$298,553.71	5,297	\$265,336.49	4,522	\$636,456.64	11,130
Amoxicillin-clavulanate	\$245,306.46	4,402	\$298,340.87	5,294	\$89,878.88	1,410	\$633,526.21	11,106
Amoxicillin-clavulanate	\$86,068.83	1,409	\$96,044.68	1,585	\$265,336.49	4,522	\$447,450.00	7,516
Augmentin	\$2,811.84	22	\$2,548.01	23	\$1,871.76	15	\$7,231.61	60
Augmentin Xr			\$112.78	1	\$633.20	4	\$745.98	5

Note: Resource Utilization Report Currently Contains Only Fee For Service Medicaid Claims

* Dollar figures represent reimbursement to pharmacies and are not representative of overall Medicaid costs.

† Molecule names accounting for less than \$500 in quarterly amount paid are not shown

Prepared by the Evidence-Based DUR Initiative, MS-DUR

Pharmacy Program Update

New Business

Special Analysis Projects

ANALYSIS OF IMPACT OF SHIFTING PATIENTS TO MSCAN UNDER 12/1/2012 GUIDELINES

Prepared by University of Mississippi MS-DUR

Excerpts from Final Report – February 5, 2013 (Tables numbers are from full report)

BACKGROUND

On December 1, 2012, the Bureau of Coordinated Care initiated an expansion of DOM's managed care plan, Mississippi Coordinated Access Network (MSCAN). The expansion of the program was in response to House Bill 421 which was passed by the Legislature during the 2012 legislative session. The Legislature authorized raising the enrollment cap on the program, making the program mandatory for many populations, and included behavioral health services. As a result of these changes, a much larger percentage of Medicaid beneficiaries will be enrolled in MSCAN in 2013. The purpose of this analysis was to examine how this increase in enrollment in MSCAN is likely to affect the medical and pharmacy services provided through the fee-for-service (FFS) program operated directly by the Division of Medicaid.

METHODS

This was a retrospective analysis using Mississippi Medicaid medical and prescription claims data from January 1, 2012 through September 30, 2012. The analysis was only run through the end of September because there is a several month lag before MS-DUR receives all of the claims for beneficiaries in MSCAN.

The general analysis design was to examine beneficiary characteristics and resource utilization metrics for beneficiaries enrolled in the FFS and MSCAN programs during this 9-month period and then examine how these numbers would change based on the new criteria for enrollment in MSCAN. The "2013 Projected" figures are based on the projected enrollment these same beneficiaries would have had using the MSCAN enrollment criteria that went into effect December 1, 2012. This analysis simply reassigns the beneficiaries between the two programs and does not take into account any changes that would occur in utilization due to MSCAN enrollment. A separate analysis is currently being conducted by MS-DUR to examine changes in resource utilization and potential outcomes pre- and post-enrollment in MSCAN. The 2013 MSCAN enrollment criteria posted on the DOM website were used to determine projected MSCAN beneficiaries. These criteria were:

COE /Required Populations	Ages	COE / Optional Populations*	Ages
001 – SSI	19 - 65	001 – SSI	0 - 19
025 – Working Disabled	19 - 65	019 – Disabled Child Living at Home	0 – 19
027 – Breast and Cervical Cancer	19 - 65	026 – Foster Care Children	0 – 19
088 – Pregnant Women	8 - 65	003 – Foster Care Children	0 - 19
088 – Infants	0 - 1	<i>* Opt Out (optional) is available within the 90 day window.</i>	
087 – Child	0 – 1		
091 - Child	0 - 1		
085 (TANF) – Family/Children	0 -1 19 - 65		

Although some of the beneficiaries in the optional populations may elect to opt out of MSCAN and revert back to the FFS program, this analysis assumes that all of the optional population beneficiaries will remain in MSCAN.

RESULTS

As shown in Table 1, only 9.4% of beneficiaries were enrolled for one month or more in MSCAN during the 9-month observation period (January 1 – September 30, 2012). During the same period, 92.4% of beneficiaries were enrolled in the FFS program for at least one month. It should be noted that 10,516 (1.8%) of beneficiaries were enrolled for at least one month in both programs due to beneficiaries opting to change their enrollment during the year. When the new MSCAN enrollment criteria are applied to these beneficiaries based on their ages on January 1, it is projected that 36.9% of these beneficiaries would have been enrolled in MSCAN.

TABLE 1: Characteristics of Eligible Beneficiaries Enrolled in FFS and MSCAN					
		2012 (Jan 1 - Sept 30)		2013 Projected*	
		FFS	MSCAN	FFS	MSCAN
Beneficiaries**		<i>row %</i>			
	#	554,664	56,164	379,426	220,879
	%	92.4%	9.4%	63.2%	36.8%
Gender***		<i>column %</i>			
	Male	59.2%	47.9%	56.0%	62.2%
	Female	40.8%	52.1%	44.0%	37.8%
Age****		<i>column %</i>			
	0 - 1	14.0%	2.1%	2.8%	30.7%
	2 - 19	60.6%	36.2%	82.8%	17.6%
	20 - 44	20.0%	27.4%	11.6%	36.1%
	45 - 65	5.2%	34.2%	2.6%	15.7%
	65+	0.2%	0.1%	0.2%	0.0%
	Average	14.2	31.5	12.2	21.3
Number eligible months (out of 9)		<i>column %</i>			
	1 - 3	11.1%	2.7%	11.8%	8.2%
	4 - 5	7.9%	1.4%	8.3%	5.8%
	6 - 7	9.3%	1.5%	10.1%	6.3%
	8	5.7%	0.9%	6.2%	3.9%
	9	66.0%	93.5%	63.7%	75.8%
	Average	7.5	7.8	7.5	8.0
Total # eligible/bene/months		4,169,956	435,860	2,844,634	1,761,182

* Based on COE for latest month eligible in 2012.

** 10,516 benes (1.8%) were in both FFS and MSCAN during 9-month period.

*** A small number (<0.1%) of beneficiaries had unknown gender

**** Age was computed as of January 1, 2012 and was with COEs to determine beneficiaries meeting criteria for switching to MSCAN in December, 2012.

The new MSCAN enrollment criteria will result in a major change in the age mix of patients in both programs. The age mix for MSCAN will shift significantly towards younger patients with the average age dropping from 31.4 years to 21.3 years.

Table 3 provides measures of payments made in the two programs. Payments were allocated to various service areas based on the place of service code assigned to the claim. Charges were allocated as follows:

- 11, 20, 50 and 72 = office visit charges
- 21 = hospital inpatient charges
- 22 = hospital outpatient charges
- 23 = hospital ER charges
- 31 = skilled nursing facility (SNF) charges
- 51, 52, 53, and 56 = psychiatric charges
- all other codes = other

TABLE 3: Medical and Pharmacy Payments					
		2012 (Jan 1 - Sept 30)		2013 Projected*	
		FFS	MSCAN	FFS	MSCAN
Medical payments					
Total medical (9 months)		\$640,227,875	\$104,324,574	\$260,532,891	\$424,267,560
Average paid bene/month	All medical	\$108.23	\$239.35	\$91.59	\$240.90
	Office visits	\$35.06	\$43.71	\$28.12	\$53.12
	Hospital Outpatient	\$4.04	\$7.69	\$3.36	\$8.28
	Hospital Inpatient (professional fees)	\$5.99	\$14.83	\$5.88	\$19.38
	Hospital ER	\$3.62	\$9.62	\$2.91	\$8.39
	SNF	\$0.16	\$0.59	\$0.17	\$0.25
	Psychiatric	\$4.43	\$33.46	\$3.45	\$15.69
	Other	\$54.91	\$129.46	\$47.70	\$135.79
Pharmacy payments					
Total pharmacy (9 months)		\$233,515,296	\$64,942,638	\$119,899,808	\$178,558,329
Average paid bene/month		\$41.63	\$149.00	\$42.15	\$101.39

* Based on COE for latest month eligible in 2012.

** 10,516 benes (1.8%) were in both FFS and MSCAN during 9-month period; figures are based on only months in FFS or MSCAN.

Note: Place of service code used to denote office visit, hospital outpatient, hospital inpatient, hospital ER, SNF, psychiatric and other.

When the new MSCAN enrollment criteria are applied, the average medical payments/bene/month showed virtually no change for MSCAN (\$239.44 to \$240.90), but average pharmacy payments/bene/month dropped significantly (\$149.06 to \$100.10). Even with this shift of patients, MSCAN beneficiaries would continue to have significantly higher medical and pharmacy costs than do FFS beneficiaries. Since this procedure simply reassigns the beneficiaries and their corresponding costs from FFS to MSCAN, this reduction in cost cannot be based on operational differences between the two programs. Based on other results regarding comorbidities of beneficiaries in both programs, this decrease is attributed to a shift of patients with fewer comorbidities moving into the MSCAN program and improving the overall patient risk profile for MSCAN.

The fact that MSCAN patients in 2013 will have more comorbidities and will be more expensive to treat than those remaining in the FFS program is further illustrated in Table 4. Table 4 shows the number of prescriptions and dollars paid for the top 10 major drug classes in the first 9 months of 2012 and projected for this population based on the 2013 MSCAN enrollment criteria. Categories where the percentage of patients being shifted to MSCAN is disproportionately higher than the overall percentage of patients to be enrolled in MSCAN are highlighted. As shown, most of the high utilization drug categories involve patients that are being shifted to MSCAN.

TABLE 4: Payments for Pharmacy Claims For Top 10 Drug Classes (based on total dollars)						
Drug Category		2012 (9 months)			2013	
		Total	FFS	MSCAN	FFS	MSCAN
Antipsychotics	N of RXs	66,315	46,844	19,471	20,596	45,719
	\$ Paid	\$23,954,785	\$17,411,543	\$6,543,241	\$7,000,160	\$16,954,624
Central nervous system agents	N of RXs	112,765	99,871	12,894	75,917	36,848
	\$ Paid	\$18,784,513	\$16,690,364	\$2,094,149	\$12,776,662	\$6,007,851
Respiratory agents	N of RXs	293,241	265,743	27,498	185,296	107,945
	\$ Paid	\$17,824,360	\$16,691,427	\$1,132,933	\$12,097,543	\$5,726,817
Antiviral agents	N of RXs	18,831	11,822	7,009	6,080	12,751
	\$ Paid	\$11,188,271	\$4,872,128	\$6,316,143	\$1,823,789	\$9,364,482
Antidiabetic agents	N of RXs	80,685	50,274	30,411	20,278	60,407
	\$ Paid	\$10,851,187	\$7,141,089	\$3,710,098	\$2,706,105	\$8,145,083
Bronchodilators	N of RXs	123,730	97,858	25,872	60,130	63,600
	\$ Paid	\$9,993,297	\$7,338,844	\$2,654,453	\$4,191,417	\$5,801,880
Coagulation modifiers	N of RXs	514	378	136	173	341
	\$ Paid	\$8,311,359	\$6,495,775	\$1,815,584	\$2,521,483	\$5,789,876
Analgesics	N of RXs	409,164	312,340	96,824	13,972	275,192
	\$ Paid	\$7,746,294	\$5,653,041	\$2,093,254	\$2,081,444	\$5,664,850
Immunologic agents	N of RXs	5,485	3,822	1,663	1,078	4,407
	\$ Paid	\$7,618,278	\$547,099	\$2,147,678	\$1,511,029	\$6,107,248
Gastrointestinal agents	N of RXs	106,915	81,450	25,465	40,664	66,251
	\$ Paid	\$7,293,079	\$5,812,163	\$1,480,916	\$2,858,298	\$4,434,780

* Based on COE for latest month eligible in 2012.

** 10,516 beneficiaries (1.8%) were in both FFS and MSCAN during 9-month period; figures are based on only months in FFS or MSCAN.

Note: Prescription drug categories are determined using Multum general drug categories.

CONCLUSION

Based on an analysis of the FFS and MSCAN programs during the first nine months of 2012, it appears that the new MSCAN enrollment criteria will have the following effects:

- Approximately 37% of beneficiaries will be enrolled in MSCAN.
- The population remaining in the FFS program will continue to have a lower risk profile than the population in the MSCAN program.

- The per bene/per month payments for medical and pharmacy in the FFS program should remain basically the same with respect to intensity of services used (increases in costs are not considered in this analysis).
- The population of beneficiaries enrolled in MSCAN in 2013 will have a lower risk profile than the population enrolled in 2012. However, the MSCAN population will still have a significantly higher risk profile compared to the FFS population.
- The per member/per month payments for medical and pharmacy will drop significantly for MSCAN, but will continue to be much higher than that for FFS.
- In future months, MS-DUR will be highlighting changes in utilization within the FFS population that are due to this shift.

DUR Board Action Requested: No action is requested – informational only.

SUBOPTIMAL ASTHMA CONTROL AND ABSENCE OF CONTROLLER THERAPY AMONG MEDICAID BENEFICIARIES WITH PERSISTANT ASTHMA

BACKGROUND

During the October 2012 P&T Committee meeting, short-acting beta agonists were reviewed. During the discussion, several members of the P&T Committee inquired about the role of Medicaid in ensuring the appropriate utilization of *rescue* inhalers in the Mississippi Medicaid population. Several members of the P&T Committee requested that the DUR Board review the utilization of *rescue* inhalers and proposed routine monitoring and educational interventions to prescribers of inhalers whose patients exhibit excessive utilization. Mississippi Medicaid currently allows for up to two canisters of short-acting beta agonists to be dispensed per calendar month. The following measures for asthma patients were identified and discussed at the November 2012 DUR Board meeting.

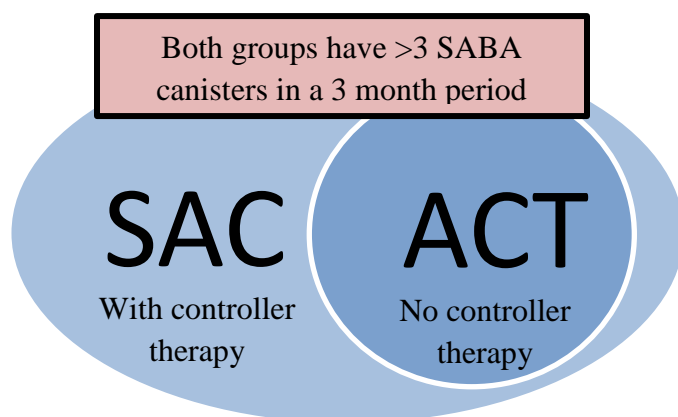
The National Quality Forum (NQF) has endorsed measures from the Pharmacy Quality Alliance (PQA) for suboptimal asthma control (SAC) and absence of controller therapy (ACT).¹ The intended level of analysis for these measures is at the health plan level (i.e., *how well is MS Medicaid performing at population asthma control?*). The measures from the NQF are presented here:

The percentage of patients with asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist (SABA) inhaler over a 90-day period and who did not receive controller therapy during the same 90-day period. Two rates are reported.

- **Suboptimal Asthma Control (SAC):** The percentage of patients with persistent asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist inhaler during the same 90-day period.
- **Absence of Controller Therapy (ACT):** The percentage of patients with asthma during the measurement period who were dispensed more than 3 canisters of short acting beta2 agonist inhalers over a 90-day period and who did not receive controller therapy during the same 90-day period.

The purpose of this report is to demonstrate an initial evaluation of the MS DOM program using the NQF asthma measures and to provide specific recommendations on educational outreach for providers and others regarding this initiative.

¹ National Quality Forum (2011). Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT). Measure 0548. Steward: Pharmacy Quality Alliance, Inc. Measure summary Available at: www.qualityforum.org

Figure 1 - Venn diagram depicting relationship of SAC and ACT**Provider Outreach**

Providers for both the SAC and ACT groups may benefit from information regarding their patient's SABA utilization. The ACT group's message would also include information noting the absence of controller therapy.

METHODOLOGY

Data from 2008-2012 were used to evaluate the NQF asthma measures. Asthma patients (defined as those who were dispensed at least two consecutive fills for any asthma medication during each measurement year) aged 5 - 50 years as of the last day of the measurement year were identified. The original NQF measure specified ages 18-50; however due to the large non-adult population in Medicaid, the measure was expanded to include beneficiaries 5-50 years of age. Of these, patients who filled one or more prescriptions for COPD medications, dornase alfa, or nasal steroid medications during the measurement year were excluded from the analysis. The medications in each of these categories are given in Table 3 at the end of this report. From the remaining patients, those who had at least 3 canisters of short acting beta agonists within 90 days were identified as those with suboptimal asthma control (SAC). Of the patients with SAC, those patients who did not receive controller therapy in the same 90 day period were defined as those with absence of controller therapy (ACT). Asthma controller therapy included inhaled steroids, long-acting beta agonists, and leukotriene inhibitors.

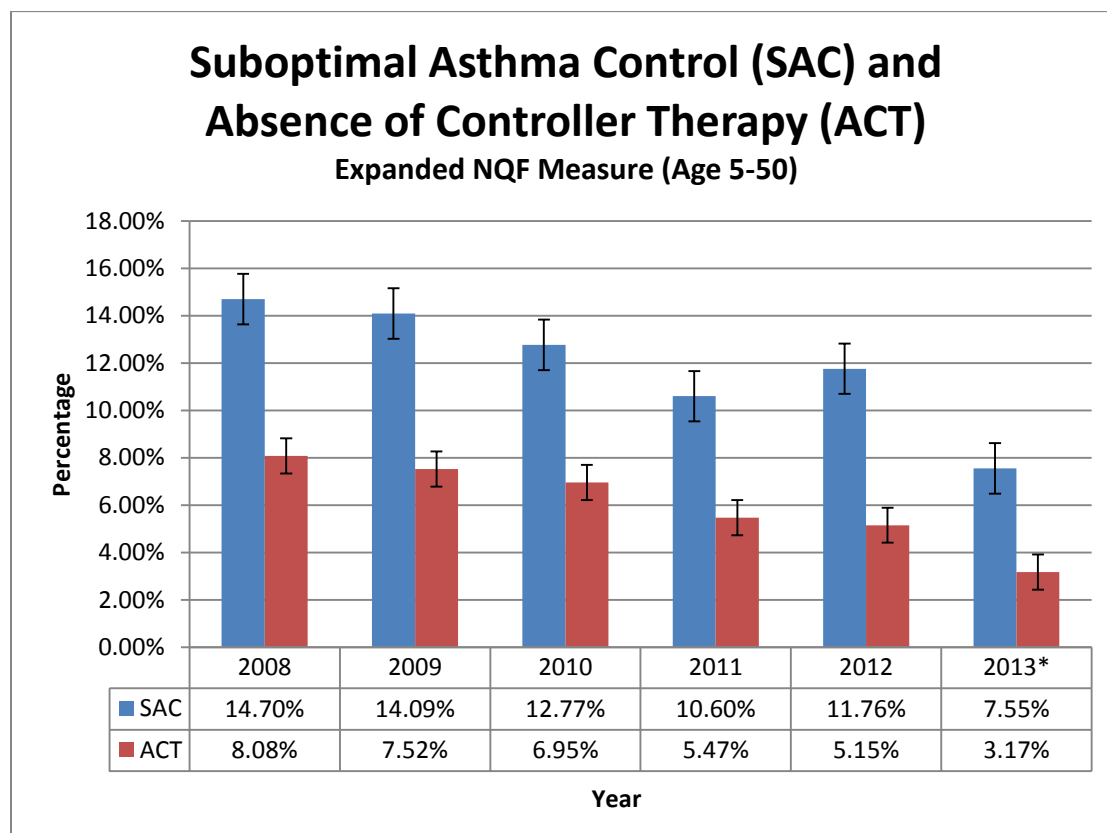
RESULTS

Table 1 provides the distribution of suboptimal asthma control and absence of controller therapy in the sample of patients with persistent asthma. The sample is stratified into the original NQF age group (18-50 years) and the expanded NQF age group (5-50 years). The values for the SAC and ACT measures are highlighted (light red). Projections for the 2013 fee-for-service (FFS) population were estimated based on the methods described in the managed Medicaid beneficiary shift analysis provided in this report. Both measures are generally trending downward year-over-year, representing better population control of asthma year-over-year. Figure 2 is a column chart of the yearly SAC and ACT measures with standard error bars.

Table 1: Distribution of asthma patients with SAC and ACT in each measurement year

Age Group	Measure	2008	2009	2010	2011	2012	2013*
NQF Age 18-50	SAC	713	811	717	424	487	136
		24.77%	24.58%	23.17%	20.37%	22.95%	26.41%
	ACT	272	329	283	158	138	44
		9.45%	9.94%	9.15%	7.59%	6.50%	8.54%
	Denominator	2,879	3,299	3,094	2,081	2,122	515
Expanded NQF Age 5-50	SAC	1,782	1,923	1,751	1,225	1,358	672
		14.70%	14.09%	12.77%	10.60%	11.76%	7.55%
	ACT	979	1,027	953	632	594	282
		8.08%	7.52%	6.95%	5.47%	5.15%	3.17%
	Denominator	12,121	13,649	13,710	11,554	11,543	8,906

*2013 measure projections were estimated based on forecasted managed Medicaid enrollment

Figure 2: Percentage of asthma patients with suboptimal asthma control (SAC) and absence of controller therapy (ACT)

*2013 measure projections were estimated based on forecasted managed Medicaid enrollment

Table 2 includes a comparison of asthma-related medical, pharmacy, and total costs in the ACT and non-ACT groups (individuals with persistent asthma, but without the overuse of SABA inhalers). The medical cost category includes physician-related expenditures and does not include inpatient costs at this time. These are non-matched, unadjusted cost estimates for the two groups. Patients in the ACT group had significantly higher mean costs in all the years as compared to those in the non-ACT group.

Table 2: Costs (in dollars) among beneficiaries in the ACT and non-ACT groups.

Type of costs	Mean costs in ACT group (standard deviation)	Mean costs in non-ACT group (standard deviation)
2008		
	n=979	n=11,142
Medical	272.14 (647.21)	125.11 (381.99)
Pharmacy	1,242.83 (804.86)	468.55 (484.82)
Total	1,516.98 (1,014.65)	593.66 (633.17)
2009		
	n=1,027	n=12,622
Medical	250.08 (550.14)	143.91 (584.03)
Pharmacy	1,321.90 (805.47)	504.87 (461.58)
Total	1,571.98 (1,018.00)	648.78 (765.24)
2010		
	n=953	n=12,757
Medical	266.76 (573.23)	145.94 (696.82)
Pharmacy	1,319.29 (772.50)	518.41 (471.22)
Total	1,586.06 (968.16)	664.36 (858.32)
2011		
	n=632	n=10,922
Medical	295.22 (910.14)	146.16 (417.73)
Pharmacy	1,453.51 (871.56)	576.19 (507.16)
Total	1,748.73 (1,239.17)	722.36 (672.82)
2012		
	n=594	n=10,949
Medical	276.52 (996.86)	138.23 (425.15)
Pharmacy	1,474.11 (853.70)	571.40 (484.99)
Total	1,750.64 (1,319.54)	709.63 (658.46)

*All differences in costs between the ACT and non-ACT groups are significant ($p < 0.001$).

CONCLUSION

Based on the discussion from the November 2012 DUR Board meeting, the general conclusion was reached that implementing a clinical edit would not be an appropriate approach to promote the appropriate use of asthma inhalers due to concerns about limiting patient's access to rescue inhaler therapy, even in the cases of excessive use. Notifying prescribers of excessive SABA utilization and absence of controller therapy through educational outreach was identified as being a more ideal approach.

Retro-DUR Monitoring and Intervention

- Monitor SAC and ACT measures and send provider outreach when their patients are flagged as belonging to either the SAC or ACT groups.

DUR Board Action Requested: Input on provider education for both SAC and ACT groups, and whether pharmacies should be included in outreach initiatives.

Future Analysis

Future analysis will be conducted to include pre- and post-intervention clinical and economic metrics, including emergency department visits, hospitalizations, and asthma-related costs.

Table 3: Drugs used for the NQF measure

Category	Drugs
Short-Acting Inhaled Beta Agonists	albuterol MDI, albuterol HFA, pirbuterol, levalbuterol HFA
Long-Acting Beta Agonists	salmeterol, formoterol
Inhaled Corticosteroids	beclomethasone, budesonide, flunisolide, fluticasone, fluticasone/salmeterol, mometasone, triamcinolone
Leukotriene Inhibitors	zafirlukast, montelukast, zileuton
Xanthines	long acting theophylline
Mast Cell Stabilizers	nedocromil, cromolyn
COPD Medications	tiotropium, ipratropium/albuterol MDI, ipratropium MDI
Nasal Steroids	beclomethasone, budesonide, flunisolide, fluticasone, mometasone, triamcinolone

*COPD = Chronic obstructive pulmonary disease

ZOLPIDEM DRUG SAFETY COMMUNICATION: FDA REQUIRES LOWER RECOMMENDED DOSES**BACKGROUND**

In January 2013, the FDA released a drug safety communication for a lower recommended dose of zolpidem.² The following are excerpts from this safety communication:

...FDA recommends that the bedtime dose of zolpidem, a widely prescribed insomnia drug, be lowered because new data show that blood levels in some patients may be high enough the morning after use to impair activities that require alertness, including driving...

...For zolpidem products, data show the risk for next-morning impairment is highest for patients taking the extended-release forms of these drugs (Ambien CR and generics). Women appear to be more susceptible to this risk because they eliminate zolpidem from their bodies more slowly than men...

Recommendations excerpt (from the FDA):

- The recommended dose of zolpidem for women should be lowered from 10 mg to 5 mg for immediate release products (Ambien, Edular, and Zolpimist) and from 12.5 mg to 6.25 mg for extended-release products (Ambien CR).
- The recommended doses of Intermezzo, a lower dose zolpidem product approved for middle-of-the-night awakenings, are not changing. At the time of Intermezzo's approval in November 2011, the label already recommended a lower dosage for women than for men.

In response to the FDA Drug Safety Communication, claims for immediate-release zolpidem 10mg, controlled-release zolpidem 12.5mg, and Intermezzo 3.75mg are set to deny at the point-of-sale (POS) for females. The purpose of this report is to assess the proportions of men and women who are on various doses of zolpidem-containing products and to seek feedback from the DUR Board on prior authorization criteria for higher doses of zolpidem in females.

Please see the Appendix for the full FDA Drug Safety Communication.

METHODOLOGY

Pharmacy claims of patients on zolpidem-containing products in 2012 were extracted. Of these, claims in September, October, and November (i.e., "current" zolpidem users) were reviewed. Patient information (particularly gender) was added to this file. Claims of patients who are

² FDA Drug Safety Communication. Zolpidem containing products: Drug Safety Communication – FDA Requires Lower Recommended Doses. Available at: <http://www.fda.gov/Drugs/DrugSafety/ucm334033.htm>. Accessed on January 28, 2013.

forecasted to be in managed care in 2013 were removed from the review. The final analysis was conducted on FFS zolpidem users in September, October, and November 2012.

RESULTS

Based on 2012 prescription claims data (Table 1), the utilization of extended-release zolpidem was very low compared to the immediate-release versions. Among females, the immediate-release 10mg and extended-release 12.5mg zolpidem were the most common dosages. There was no utilization of Intermezzo in 2012.

Table 1: Dosage of zolpidem by gender in 2012 (prescription count)

Drugs and dosage	Male (N, %)	Female (N, %)
Immediate-release products (Ambien, Edular, Zolpimist)		
5 mg	174 (20.71)	631 (17.52)
10 mg	666 (79.29)	2971 (82.48)
Extended-release product (Ambien CR)		
6.25 mg	0	1 (7.69)
12.5 mg	2	12 (92.31)

Prescription claims data from September, October, and November 2012 were used to estimate the number of current users of zolpidem after accounting for managed Medicaid beneficiary shifts in 2013 (Table2). Based on this, it is estimated that zolpidem prescriptions will reject at the POS for 183 females on the immediate release zolpidem 10mg and for four women on the extended-release zolpidem 12.5mg. These prescriptions will require a manual prior authorization to be filled.

Table 2: Dosage of zolpidem by gender (current users)

Drugs and dosage	Male (N, %)	Female (N, %)
Immediate-release products (Ambien, Edular, Zolpimist)		
5 mg	32 (31.68)	56 (23.43)
10 mg	69 (68.32)	183 (76.57)
Extended-release product (Ambien CR)		
6.25 mg	0	0
12.5 mg	0	4

CONCLUSION

DUR Board Action Requested: The Mississippi Division of Medicaid is seeking input from the DUR Board on prior authorization criteria for prescribers seeking higher doses of zolpidem for their female patients.

DEXTROMETHORPHAN AND CODEINE-CONTAINING COUGH SYRUP UTILIZATION

BACKGROUND

The Mississippi Division of Medicaid asked MS-DUR to review codeine (COD)-containing cough syrup utilization among Medicaid beneficiaries, compared to dextromethorphan (DM) products, to examine potential abuse and misuse. Some other state Medicaid programs are currently reviewing their controlled substances utilization and implementing changes to reduce the likelihood of abuse and misuse. Idaho Medicaid has recently implemented a 2 prescription fill of 120ml per beneficiary in a rolling 6 month period. MS-DUR modeled this scenario to see the impact of implementing a similar change in the Mississippi Medicaid population.

METHODOLOGY

Pharmacy claims of patients on cough preparations in 2012 were reviewed and prescriptions for products containing dextromethorphan (DM) and codeine (COD) were identified.

RESULTS

The majority of prescription claims for these products were filled for beneficiaries age 18 and under. This is understandable since this is the largest population in the Medicaid program and cough syrups are used most often for children and adolescents.

Table 1: Distribution of beneficiaries on cough preparations containing DM and COD by age.

Age	DM Claims (n, %)	COD Claims (n, %)
	n = 62,751	n = 17,570
<=18	58,802 (93.71)	16,906 (96.22)
>18 to <=25	1,393 (2.22)	238 (1.35)
>25 to <=35	981 (1.56)	212 (1.21)
>35 to <=45	498 (0.79)	81 (0.46)
>45 to <=55	357 (0.57)	62 (0.35)
>55 to <=65	285 (0.45)	41 (0.23)
>65	435 (0.69)	30 (0.17)

Table 2 provides the distribution of the quantities dispensed in a single prescription for DM and COD cough preparations. About 74% of the COD cough preparation prescriptions are currently written for ≤ 120 ml. If a quantity limit of a 120ml per prescription of COD preparations were implemented, about 26% of the COD prescriptions would deny at the POS and would need to be resubmitted for a quantity ≤ 120 ml. There were a small number of single COD prescriptions > 480 ml. This distribution also illustrates how COD prescriptions are generally written for lower quantities than are DM prescriptions (approximately 44% of DM prescriptions were for > 120 ml). This indicates that most prescribers are already considering the abuse potential for COD medications.

Table 2: Distribution of prescriptions of cough syrup containing DM and COD (2012)

Quantity	DM Claims (n, %)	COD Claims (n, %)
	n = 91,658	n = 20,606
≤ 60	3,147 (3.43)	5,452 (26.46)
> 60 to ≤ 90	5,259 (5.74)	1,626 (7.89)
> 90 to ≤ 120	42,809 (46.71)	8,151 (39.56)
> 120 to ≤ 150	4,409 (4.81)	1,287 (6.25)
> 150 to ≤ 180	16,469 (17.97)	1,497 (7.26)
> 180 to ≤ 240	16,566 (18.07)	1,982 (9.62)
> 240 to ≤ 480	2,935 (3.20)	563 (2.73)
> 480	64 (0.07)	48 (0.23)

Table 3 shows the distribution of beneficiaries by total quantity received for those with ≤ 2 fills in a rolling 6 month period and those with > 2 fills in a rolling 6 month period. Only 6% of beneficiaries receiving ≤ 2 fills obtained a total quantity exceeding 240ml. However, 25% of the beneficiaries receiving >2 fills obtained a total quantity exceeding 240ml.

Table 3: Cumulative quantity of DM and COD containing prescriptions for each beneficiary by number of fills in a 6 month rolling period

Cumulative Quantity	Benes Getting DM Rx (n, %)	Benes Getting COD Rx (n, %)
≤ 2 fills in 6 months	n = 58,298	n = 16,092
≤ 60	1,500 (2.57)	4,013 (24.94)
>60 to ≤ 90	2,530 (4.34)	1,219 (7.58)
>90 to ≤ 120	19,570 (33.57)	5,953 (36.99)
>120 to ≤ 150	2,349 (4.03)	879 (5.46)
>150 to ≤ 180	8,222 (14.10)	1,209 (7.51)
>180 to ≤ 240	13,388 (22.96)	1,846 (11.47)
>240 to ≤ 480	9,326 (16.00)	874 (5.43)
>480	1,413 (2.42)	99 (0.62)
>2 fills in 6 months	n = 4,456	n = 1,485
≤ 60	9 (0.20)	238 (16.03)
>60 to ≤ 120	175 (3.93)	445 (29.97)
>120 to ≤ 240	569 (12.76)	430 (28.96)
>240 to ≤ 480	2,451 (55.00)	282 (18.99)
>480	1,252 (28.10)	90 (6.06)

CONCLUSION

Overall, only 9.3% (1,345 of 16,092) of beneficiaries receiving prescriptions for COD products exceeded the 240ml limit in a rolling 6 month period. An edit limiting beneficiaries to two 120ml prescriptions in a rolling 6 month period would address the higher utilization by these individuals but would have limited effect on overall utilization of COD containing cough products. The edit used in this report was an example from another Medicaid program and there may be other quantity edits or limitations that may be recommended.

DUR Board Action Requested: The Division of Medicaid is seeking a recommendation from the Board as to whether this is a significant enough problem that an edit should be implemented and what the specific limitation should be if an edit is recommended.

Exceptions Monitoring Criteria Recommendations

**MISSISSIPPI MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
EXCEPTIONS MONITORING CRITERIA RECOMMENDATIONS**

Criteria Recommendations**1. Use of TCAs in patients treated with linezolid or intravenous methylene blue**

Message: From October 2012 to December 2012, the FDA updated the class labeling of tricyclic antidepressants. Prescribing tricyclic antidepressants to a patient who is being treated with linezolid is contraindicated because of an increased risk of serotonin syndrome.

Exception Type: DDI - Drug-drug interaction

Field 1

Tricyclic antidepressants

Field 2

linezolid

References:

FDA Drug Safety Labeling Changes. October 2012. Available at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm326133.htm>

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm330881.htm>

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm332340.htm>

2. Drugs affecting the renin-angiotensin system along with aliskiren in patients with diabetes

Message: From October 2012 to December 2012, the FDA updated the labeling of drugs affecting the renin-angiotensin system to include a warning that aliskiren should not be co-administered with them in patients with diabetes. Dual blockade of the RAS with angiotensin receptor blockers, ACE inhibitors, or aliskiren is associated with increased risks of hypotension, hyperkalemia, and changes in renal function (including acute renal failure) compared to monotherapy.

Exception Type: DDI - Drug-drug interaction

Field 1

Avalide

Diovan

Edarbi

Edarbyclor

Lotrel

Micardis

Exforge

Twynsta

Field 2

Diabetes

References:

FDA Drug Safety Labeling Changes. October 2012. Available at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm326133.htm>

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm330881.htm>

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm332340.htm>

3. Combigan (brimonidine tartrate/timolol maleate) 0.2%/0.5% ophthalmic solution in neonates and infants

Message: In October 2012, the FDA updated the labeling of Combigan (brimonidine tartrate/timolol maleate) ophthalmic solution to include that it is contraindicated in neonates and infants (under the age of 2 years).

Exception Type: CAP - Pediatric warning

Field 1

Combigan

Field 2

Neonates and infants (under the age of 2 years).

References:

FDA Drug Safety Labeling Changes. October 2012. Available at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm327514.htm>

4. Letairis (ambrisentan) tablets in patients with Idiopathic Pulmonary Fibrosis

Message: In October 2012, the FDA updated the labeling of Letairis (ambrisentan) tablets to include a contraindication in patients with Idiopathic Pulmonary Fibrosis (IPF) including IPF patients with pulmonary hypertension. Use of Letairis in such patients is known to cause asthenia, dizziness, and fatigue.

Exception Type: DDC - Drug-disease contraindication

Field 1

Letairis

Field 2

Idiopathic Pulmonary Fibrosis and pulmonary hypertension

References:

FDA Drug Safety Labeling Changes. October 2012. Available at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm233391.htm>

5. Zytiga (abiraterone acetate) Tablets in pregnant women

Message: In December 2012, the FDA updated the labeling of Zytiga tablets to include a warning that it is contraindicated among pregnant women due to its ability to cause fetal harm.

Exception Type: DDC - Drug-disease contraindication

Field 1

Zytiga

Field 2

Pregnancy

References:

FDA Drug Safety Labeling Changes. December 2012. Available at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm314608.htm>

Appendix



Risk of next-morning impairment after use of insomnia drugs; FDA requires lower recommended doses for certain drugs containing zolpidem (Ambien, Ambien CR, Edluar, and Zolpimist)

Safety Announcement

[1-10-2013] The U.S. Food and Drug Administration (FDA) is notifying the public of new information about zolpidem, a widely prescribed insomnia drug. FDA recommends that the bedtime dose be lowered because new data show that blood levels in some patients may be high enough the morning after use to impair activities that require alertness, including driving. Today's announcement focuses on zolpidem products approved for bedtime use, which are marketed as generics and under the brand names Ambien, Ambien CR, Edluar, and Zolpimist.

FDA is also reminding the public that all drugs taken for insomnia can impair driving and activities that require alertness the morning after use. Drowsiness is already listed as a common side effect in the drug labels of all insomnia drugs, along with warnings that patients may still feel drowsy the day after taking these products. Patients who take insomnia drugs can experience impairment of mental alertness the morning after use, even if they feel fully awake.

FDA urges health care professionals to caution all patients (men and women) who use these zolpidem products about the risks of next-morning impairment for activities that require complete mental alertness, including driving. For zolpidem products, data show the risk for next-morning impairment is highest for patients taking the extended-release forms of these drugs (Ambien CR and generics). Women appear to be more susceptible to this risk because they eliminate zolpidem from their bodies more slowly than men (see Data Summary below).

Because use of lower doses of zolpidem will result in lower blood levels in the morning, FDA is requiring the manufacturers of Ambien, Ambien CR, Edluar, and Zolpimist to lower the recommended dose. FDA has informed the manufacturers that the recommended dose of zolpidem for women should be lowered from 10 mg to 5 mg for immediate-release products (Ambien, Edluar, and Zolpimist) and from 12.5 mg to 6.25 mg for extended-release products (Ambien CR). FDA also informed the manufacturers that, for men, the labeling should recommend that health care professionals consider prescribing the lower doses—5 mg for immediate-release products and 6.25 mg for extended-release products (see Zolpidem Dosing Recommendations for Adults).

The recommended doses of Intermezzo, a lower dose zolpidem product approved for middle-of-the-night awakenings, are not changing. At the time of Intermezzo's approval in November 2011, the label already recommended a lower dosage for women than for men.

FDA is continuing to evaluate the risk of impaired mental alertness with other insomnia drugs, including over-the-counter (OTC) drugs available without a prescription.

To decrease the potential risk of impairment with all insomnia drugs, health care professionals should prescribe, and patients should take, the lowest dose capable of treating the patient's insomnia. Patients who drive or whose activities require full alertness the morning after use of an insomnia drug should discuss the appropriateness of their medicine with their health care professional (see Insomnia Medicines below).

FDA has prepared a list of [questions and answers](#) to provide an additional overview of this safety issue.

Facts about Zolpidem

- A sedative-hypnotic (sleep) medicine used in adults for the treatment of insomnia
- Marketed as generics and under the brand-names Ambien, Ambien CR, Edluar, Zolpimist, and Intermezzo
- In 2011, about 39 million prescriptions for zolpidem products were dispensed, and about 9 million patients received zolpidem products from U.S. outpatient retail pharmacies, of which 63% of the patients were female. Extended-release zolpidem products (Ambien CR[®] and generics) accounted for 11% (4.4 million prescriptions) of the zolpidem market, immediate-release products accounted for 89% (35 million prescriptions) of the market in Y2011.¹

Additional Information for Patients

- Patients who take insomnia medicines can experience decreased mental alertness the morning after use, even if they feel fully awake.
- Zolpidem extended-release (Ambien CR and generics) products may not be the right medication choice for patients (men or women) with insomnia who need to drive or perform activities that require full alertness the next morning.
- For women, FDA is requiring the manufacturers of zolpidem-containing products to lower the recommended doses of Ambien and Ambien CR, Edluar, and Zolpimist in the professional drug labels that accompany the medications. FDA is also requiring manufacturers to recommend that health care professionals consider prescribing the lower dose of these drugs in men (see Zolpidem Dosing Recommendations for Adults).

- If you are currently taking the 10 mg or 12.5 mg dose of a zolpidem-containing insomnia medicine, continue taking your prescribed dose as directed until you have contacted your health care professional to ask for instructions on how to safely continue to take your medicine. Each patient and situation is unique, and the appropriate dose should be discussed with your health care professional.
- The lower zolpidem dose will be effective in most women and many men.
- Read the Medication Guide that comes along with your zolpidem prescription for additional information.
- For other insomnia medicines, talk to your health care professional about ways to take the lowest dose that treats your symptoms.
- Take your insomnia medicine exactly as prescribed.
- Over-the-counter (OTC) insomnia medicines that are available without a prescription should not be considered safer than prescription insomnia medicines for next-morning alertness and driving.
- Contact your health care professional if you have any questions or concerns about zolpidem or other insomnia medicines.
- Report side effects from the use of zolpidem or other insomnia medicines to FDA's MedWatch program, using the information in the "Contact FDA" box at the bottom of this page.

Additional Information for Health Care Professionals

- Immediate-release products: FDA is requiring the manufacturers of certain immediate-release zolpidem products (Ambien, Edluar, and Zolpimist) to lower the recommended dose. FDA has informed manufacturers that:
 - The recommended initial dose for women should be lowered from 10 mg to 5 mg, immediately before bedtime.
 - The drug labeling should recommend that health care professionals consider prescribing a lower dose of 5 mg for men. In many men, the 5 mg dose provides sufficient efficacy.
 - The drug labeling should include a statement that, for both men and women, the 5 mg dose could be increased to 10 mg if needed, but the higher dose is more likely to impair next-morning driving and other activities that require full alertness.
- Extended-release products: FDA is also requiring the manufacturer of extended-release zolpidem (Ambien CR) to lower the recommended dose. FDA has informed the manufacturer that:
 - The recommended initial dose for women should be lowered from 12.5 mg to 6.25 mg, immediately before bedtime.
 - The drug labeling should recommend that health care professionals consider prescribing a lower dose of 6.25 mg in men. In many men, the 6.25 mg dose provides sufficient efficacy.

- The drug labeling should include a statement that, for both men and women, the 6.25 mg dose can be increased to 12.5 mg if needed, but the higher dose is more likely to impair next-morning driving and other activities that require full alertness.
- FDA has informed the manufacturers that the recommended zolpidem doses for women and men should be different because women eliminate zolpidem from their bodies at a slower rate than men.
- For zolpidem and other insomnia drugs, prescribe the lowest dose that treats the patient's symptoms.
- FDA urges health care professionals to caution all patients (men and women) who use these products about the risks of next-morning impairment for activities that require complete mental alertness, including driving.
- Inform patients that impairment from sleep drugs can be present despite feeling fully awake.
- Encourage patients to read the Medication Guide when they receive their zolpidem prescription.
- Report adverse events involving zolpidem or other insomnia drugs to FDA's MedWatch program, using the information in the "Contact FDA" box at the bottom of this page.

Data Summary

Driving simulation and laboratory studies recently submitted to FDA indicate that zolpidem blood levels above approximately 50 ng/mL appear capable of impairing driving to a degree that increases the risk of a motor vehicle accident. In pharmacokinetic trials of 10 mg Ambien (or bioequivalent zolpidem products) that included approximately 250 men and 250 women, about 15% of women and 3% of men had zolpidem concentrations that exceeded 50 ng/mL approximately 8 hours post-dosing. Three measurements in women and one in men were ≥ 90 ng/mL at about 8 hours after use.

A higher percentage of both men and women experience potentially impairing morning zolpidem levels after use of extended-release zolpidem products (Ambien CR or generic equivalents). In pharmacokinetic trials of zolpidem extended-release 12.5 mg, approximately 33% of women and 25% of men had zolpidem blood concentrations exceeding 50 ng/mL approximately 8 hours post-dosing. About 5% of patients had blood levels ≥ 100 ng/mL.

In studies of zolpidem extended-release 6.25 mg, at 8 hours after dosing, about 15% of adult women and 5% of adult men had a zolpidem level of ≥ 50 ng/mL, whereas for both elderly men and women, about 10% had such a zolpidem level.

FDA is continuing to evaluate the risk of next-morning impairment with other insomnia drugs.

Zolpidem Dosing Recommendations for Adults (Non-Elderly)

	Dosing recommendations in current drug label for zolpidem	FDA's proposed new dosing recommendations for zolpidem
Ambien, Edluar, Zolpimist	<u>Men and Women:</u> 10 mg once daily, immediately before bedtime	<u>Women:</u> 5 mg once daily, immediately before bedtime <u>Men:</u> 5 or 10 mg once daily, immediately before bedtime
Ambien CR	<u>Men and Women:</u> 12.5 mg once daily, immediately before bedtime	<u>Women:</u> 6.25 mg once daily, immediately before bedtime <u>Men:</u> 6.25 or 12.5 mg once daily, immediately before bedtime

Insomnia Medicines

Prescription Insomnia Medicines

Generic name	Found in brand name(s)
zolpidem tartrate	Ambien, Ambien CR, Edluar, Zolpimist, Intermezzo
butabarbital sodium	Butisol sodium
pentobarbital and carbromal	Carbrital
flurazepam hydrochloride	Dalmane
quazepam	Doral
triazolam	Halcion
eszopiclone	Lunesta
ethchlorvynol	Placidyl
estazolam	Prosom
temazepam	Restoril
ramelteon	Rozerem
secobarbital sodium	Seconal
doxepin hydrochloride	Silenor
zaleplon	Sonata

Over-the-counter (OTC) Insomnia Medicines

Generic name	Common brand name(s)
diphenhydramine	Benadryl Also in many cold and headache combination products*
doxylamine	Unisom Also in many cold and headache combination products*

*Be sure to always read the Drug Facts box on OTC medicines.

Reference

1. IMS, Vector One: National (VONA) and Total Patient Tracker (TPT). Year 2011. Extracted June 2012.

Contact FDA

1-800-332-1088

1-800-FDA-0178 Fax

Report a Serious Problem

MedWatch Online

Regular Mail: Use postage-paid FDA Form 3500

Mail to: MedWatch 5600 Fishers Lane

Rockville, MD 20857

Related Information

- [FDA Drug Safety Communication: Risk of next-morning impairment after use of insomnia drugs; FDA requires lower recommended doses for certain drugs containing zolpidem \(Ambien, Ambien CR, Edluar, and Zolpimist\)](#)
- [Questions and Answers](#)