

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



MISSISSIPPI DIVISION OF
MEDICAID

**May 16, 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

May 16, 2013

Welcome	Mark Reed, M.D. (Chair)
Old Business	Mark Reed, M.D. (Chair)
Approval of February 2013 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 11, 20</i>
Top 15 Drug Classes and Top 25 Drug Detail – Number of Claims	<i>pages 23, 28</i>
Synagis (palivizumab) Utilization for 2012-2013 RSV Season	<i>page 32</i>
Pharmacy Program Update	Shannon Hardwick, R.Ph.
Medicaid Update	
Program Integrity Update	Andrea McNeal & Laura Sue Reno
New Business	Kyle D. Null, Pharm.D., Ph.D. &
<i>Special Analysis Projects</i>	Ben Banahan, Ph.D.
Activities to Identify Potential Drug Abuse and Diversion Cases (Banahan)	<i>page 36</i>
Controlled Substances Utilization and Monitoring Suggestions (Null)	<i>page 37</i>
“Grandfathering” Criteria on the Preferred Drug List (Banahan)	<i>page 42</i>
Condition Overview: Coronary Artery Disease (Null)	<i>page 44</i>
Smoking Cessation Utilization Review and Initiatives (Null)	<i>page 52</i>
<i>Exceptions Monitoring</i>	
Exceptions Monitoring Criteria Recommendations	<i>page 61</i>
<i>Appendix</i>	
Lipid Lowering Therapy in Coronary Artery Disease Education Letter	<i>page 65</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 FEBRUARY 19, 2013 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	8	4

Also Present:**DOM Staff:**

Shannon Hardwick, R.Ph., DOM Clinical Pharmacist, DUR Coordinator; Terri Kirby, R.Ph., DOM Clinical Pharmacist

MS-DUR Staff:

Kyle Null, Pharm.D., Ph.D., Clinical Director; Ben Banahan, Ph.D., Project Director

Xerox Staff:

Leslie Leon, Pharm.D.

Visitors:

Darlene Bitel, Shire US, Inc.; Jason Norman, Teva Pharma; Juan Trippe, Reckitt Benckiser; Hope Berry, Forest Labs; Dan Barbera, Lilly; Brian Berhow, Sunovion; Ian Clarke, IPSEN; Callista Goheen, Medimmune

Call to Order: Dr. Mark Reed, Chairman of the Board, called the meeting to order at 1:56 pm. Dr. Reed asked for a motion to accept the minutes from the meeting of November 15, 2012. Dr. Hubble made a motion to accept the minutes with a second from Dr. Simmons. All voted in favor of the motion.

Resource Utilization Review:

Dr. Null noted that no special issues have emerged with respect to the resource utilization during the last three months. He mentioned the typical seasonal decline in utilization during the month of December and noted that the decrease in utilization was more pronounced due to beneficiary movement into the managed Medicaid plans on December 1, 2012.

Pharmacy Program Update:

Ms. Hardwick thanked the Board for being flexible about the change in the meeting date to the American Drug Utilization Review Society (ADURS) meeting in Arizona that she, Dr. Null and Dr. Banahan would be attending on the regularly scheduled meeting date. She noted that Ms. Clark is speaking at a conference and will be present at the next Board meeting. Ms. Hardwick presented the Board the new DOM logo and also provided the Winter Medicaid Pharmacy Newsletter.

Dr. Banahan provided update on Suboxone utilization, noting that many Suboxone beneficiaries shifted into MS-CAN following the legislative action which moved select beneficiaries beginning on December 1, 2012. Dr. Banahan mentioned that many point of sale (POS) claim denials were due to lack of a diagnosis in the medical records. Pharmacists are able to input a diagnosis code at the POS and communicating that information to pharmacists has reduced the number of resubmission attempts. Dr. Banahan noted that the purpose of moving Suboxone users into SmartPA was to reduce the manual prior authorization (PA) burden on DOM's staff in addition to encouraging prescribers to titrate beneficiaries off of therapy.

New Business:*Shift to MS-CAN*

Dr. Banahan provided an overview of the analysis conducted for DOM on how increased enrollment in MS-CAN might affect pharmacy services. Dr. Banahan noted that the most recent shift of beneficiaries to MS-CAN would significantly reduce prescription volume for fee-for-service Medicaid and the MS-CAN population was slightly sicker, having more conditions and comorbidities, compared to the FFS population. Mr. Smith inquired about the 2013 MS-CAN projections, specifically about how the data were extrapolated. Dr. Banahan noted that the beneficiaries were projected to move into MS-CAN based on their FFS Medicaid category of eligibility and that the projections did not account for differences in MS-CAN plan offerings, projected utilization changes, preferred drug list or clinical edit differences between the FFS and MS-CAN plans. Dr. Davis asked why the medical costs (Table 3, page 47) were relatively flat for MS-CAN beneficiaries between 2012 and the projected 2013 expenditures, whereas the prescription costs dropped for MS-CAN. Dr. Banahan noted that projection just assigns FFS beneficiaries and their corresponding costs into MS-CAN, so the expenditures are not reflective of operational differences between the two programs. Additionally, Dr. Banahan noted that the changes in prescription expenditures costs would be more responsive to changes in comorbidity mix than medical expenditures, partially because the sicker patients typically utilize more monthly medications that may be more costly, but the average monthly prescriber visits do not necessarily increase.

Suboptimal Asthma Control

Dr. Null reviewed the suboptimal asthma control analysis. Two quality measures were used in the analysis: "suboptimal asthma control" (SAC) and "absence of controller therapy" (ACT). The criteria for these measures were taken from the measures developed by the Pharmacy Quality Alliance and endorsed by the National Quality Forum. Dr. Null described how the measures have been improving slowly between 2008 and 2013. Dr. Null reported on the North Carolina Medicaid program related to asthma control.

Dr. McIntosh described non-branded educational materials that are available that may be used as a part of education initiatives targeted to providers for patient education. Dr. Reed asked that additional information be brought to the next meeting about the North Carolina edit for consideration by the Board. Dr. Davis asked if anyone knew what MS-CAN programs were doing about clinical edits related to LABAs and rescue inhalers. Dr. Hubble commented that educational materials for patients would be great, noting that the educational materials would help providers meet meaningful use requirements for

electronic health records (EHR) systems. Providers need to give patients materials and need to have URL links in order to incorporate it into their EHR system. Dr. McIntosh pointed out educational materials in a generic template could be modified to be specific to the clinic using the materials. Mr. Smith asked about the need for pharmacy education materials and commented that he did not believe that sending educational materials to pharmacies related to the asthma quality measures may not be the best use of resources. Dr. McIntosh indicated that community pharmacies could play a role in making sure patients are filling and using their controller medicines when needed, but providing education materials sent from Medicaid may not be useful for pharmacists. Mr. Smith pointed out that often there has to be a hard edit that prevents payment in order to be sure pharmacy is involved in helping meet the quality measure. Ms. Kirby discussed issues related to how such an edit could be implemented; including pharmacist overrides by inputting diagnosis codes at the POS for exercise-induced or cough-variant asthma.

Zolpidem Drug Safety Communication

Dr. Null reviewed the FDA drug safety communication for lower recommended doses of zolpidem, noting that most females on the immediate-release are taking the 10mg dose. Because this is a safety communication, a hard edit has already been implemented that will deny a 10mg dose for females at the POS. Dr. Null asked what would be a reasonable criteria for PA when requested. Dr. Simmons noted that most often it will be patient reporting failure on 5mg. Dr. Simmons noted that finding another option may be difficult in that sedation effects of other medications that could be used may be worse. Dr. Smith asked whether there was any information provided by the FDA that would indicate appropriate clinical situations that would warrant a female to be on a higher dose of zolpidem. Dr. Null replied that no information indicating exceptions was provided in the FDA drug safety communication.

Dr. McIntosh pointed out that if it is a safety issue DOM should not approve zolpidem 10mg or equivalent doses for females. Dr. Simmons and Mr. Smith agreed that if the FDA does not recommend an alternative or situations where 10mg would be acceptable, then DOM should recommend a change to another therapy but not have criteria for approving PAs. Dr. Reed summarized the recommendation that DOM not cover the 10mg dose for females. Dr. Null noted that this month's education mailing will be directed at current users of 10mg for females notifying them about hard edit and restriction. Mr. Smith pointed out that rejection message should make it clear that other medication will be needed and not to request a PA. The motion was passed unanimously.

Dextromethorphan and Codeine-Containing Cough Syrup Utilization

Dr. Null reviewed the results from the MS-DUR analysis on dextromethorphan and codeine-containing cough syrup. Dr. Null noted that other states had implemented edits to limit potential misuse and abuse, pointing out that Idaho Medicaid had recently implemented a 2 prescription fill of 120ml per beneficiary in a rolling 6 month period. Dr. Null noted that most use of these medications occurred in patients 18 and under. Dr. Reed pointed out that older kids may need larger quantities, so an quantity edit of 120ml may leave some without medication who legitimately need larger quantities. Dr. Null mentioned that the Idaho Medicaid limits were used as an example in this analysis and that MS-DUR was not recommending those limits be placed. Dr. Reed also noted the need to be able to single out use for cough and also include hydrocodone. Dr. Hubble reported on a recent patient that overdosed on a cough medication. Dr. McIntosh indicated that for adults they dispense 240ml and often give one refill. Dr. Null commented that based on the data, there did not appear to be a real problem and the Board did not believe this needed to be examined further.

Other Business

Exceptions monitoring recommendations were taken as a block and were unanimously approved.

Next Meeting Information:

Dr. Reed announced next meeting date is May 16, 2013 at 2:00p.m. and thanked everyone for making the effort to attend the DUR Board meeting in order to have a quorum. The meeting adjourned at 3:56 pm.

Submitted,
MS 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	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Adrenals	\$1,805,384.68	12,710	\$1,711,776.07	12,596	\$3,727,823.22	24,684	\$7,244,983.97	49,990
Budesonide	\$1,495,510.04	3,324	\$1,407,359.08	3,098	\$3,093,003.08	6,746	\$5,995,872.20	13,168
Prednisolone	\$98,860.89	5,983	\$103,894.73	5,970	\$202,326.03	10,761	\$405,081.65	22,714
Fluticasone	\$67,284.46	448	\$61,918.76	415	\$144,573.23	956	\$273,776.45	1,819
Beclomethasone	\$40,414.37	295	\$40,212.00	294	\$86,227.44	637	\$166,853.81	1,226
Budesonide-formoterol	\$39,189.13	170	\$33,742.04	148	\$82,905.43	358	\$155,836.60	676
Mometasone	\$25,778.13	181	\$26,000.62	185	\$44,334.66	320	\$96,113.41	686
Formoterol-mometasone	\$16,518.08	71	\$15,567.14	65	\$29,309.11	132	\$46,316.31	206
Methylprednisolone	\$8,174.84	619	\$8,546.11	644	\$16,612.12	1,248	\$33,333.07	2,511
Prednisone	\$6,756.40	1,205	\$7,544.05	1,358	\$14,820.33	2,668	\$29,120.78	5,231
Dexamethasone	\$3,876.21	310	\$3,331.39	312	\$6,791.24	601	\$13,998.84	1,223
Hydrocortisone	\$1,693.14	66	\$1,930.89	64	\$3,385.18	136	\$7,009.21	266
Fludrocortisone	\$1,017.74	36	\$1,113.42	40	\$2,928.05	119	\$5,059.21	195
Flunisolide Nasal	\$303.66	1	\$577.05	2	\$607.32	2	\$1,488.03	5
Antipsychotics (atypical And Typical)	\$1,907,846.93	6,338	\$1,706,182.90	5,765	\$3,598,355.15	12,981	\$7,212,384.98	25,084
Aripiprazole	\$887,655.01	1,252	\$773,979.73	1,132	\$1,507,999.33	2,449	\$3,169,634.07	4,833
Quetiapine	\$406,011.80	1,087	\$363,166.89	951	\$804,695.59	2,249	\$1,573,874.28	4,287
Risperidone	\$247,216.65	2,707	\$222,887.02	2,491	\$510,519.84	5,607	\$980,623.51	10,805

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	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Olanzapine	\$183,243.71	344	\$178,407.12	330	\$397,335.26	716	\$758,986.09	1,390
Ziprasidone	\$43,450.49	113	\$38,600.45	101	\$101,692.92	202	\$183,743.86	402
Asenapine	\$43,956.51	89	\$32,992.03	68	\$88,666.43	171	\$165,614.97	328
Paliperidone	\$30,216.88	38	\$27,780.99	34	\$54,514.26	79	\$112,512.13	151
Lurasidone	\$18,676.12	31	\$20,713.88	32	\$36,859.06	61	\$76,249.06	124
Haloperidol	\$10,329.55	261	\$9,923.30	242	\$19,114.88	534	\$39,367.73	1,037
Chlorpromazine	\$19,454.92	194	\$15,507.24	158	\$30,866.36	318	\$39,010.42	388
Clozapine	\$8,749.41	75	\$7,587.49	63	\$19,898.71	182	\$36,235.61	320
Iloperidone	\$3,040.05	5	\$7,656.93	11	\$7,294.08	10	\$17,991.06	26
Perphenazine	\$2,463.28	34	\$2,868.96	42	\$9,643.26	118	\$14,975.50	194
Prochlorperazine	\$783.10	58	\$623.04	50	\$1,684.84	100	\$3,090.98	208
Thioridazine	\$803.73	28	\$778.85	27	\$1,412.55	52	\$2,995.13	107
Loxapine	\$476.19	6	\$628.39	7	\$1,738.75	25	\$2,843.33	38
Pimozide	\$388.27	4	\$294.63	4	\$1,659.36	22	\$2,342.26	30
Fluphenazine	\$357.09	16	\$407.64	16	\$1,532.08	39	\$2,296.81	71
Trifluoperazine	\$318.45	6	\$1,209.24	14	\$566.39	14	\$2,094.08	34
Thiothixene	\$255.72	9	\$169.08	9	\$661.20	33	\$1,086.00	51
Amphetamines	\$1,460,203.97	8,576	\$1,453,366.36	8,466	\$3,194,171.23	18,833	\$6,107,741.56	35,875
Lisdexamfetamine	\$829,014.28	4,608	\$814,391.21	4,514	\$1,820,705.25	10,125	\$3,464,110.74	19,247
Amphetamine-dextroamphetamine	\$596,550.44	3,785	\$605,491.58	3,767	\$1,294,721.74	8,281	\$2,496,763.76	15,833
Dextroamphetamine	\$34,639.25	183	\$33,483.57	185	\$78,744.24	427	\$146,867.06	795

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	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Hemostatics	\$1,585,065.83	56	\$963,815.94	26	\$2,264,242.18	80	\$4,813,123.95	162
Antihemophilic Factor	\$528,152.62	26	\$311,958.12	10	\$1,590,309.96	60	\$2,430,420.70	96
Anti-inhibitor Coagulant Complex	\$588,035.57	5	\$330,209.03	2	\$185,032.69	1	\$1,103,277.29	8
Antihemophilic Factor-von Willebrand Fa	\$455,254.50	6	\$79,910.49	4	\$96,138.16	7	\$631,303.15	17
Coagulation Factor Viia			\$181,295.64	4	\$308,195.55	5	\$489,491.19	9
Coagulation Factor Ix	\$10,922.63	2	\$60,030.19	3	\$83,682.41	3	\$154,635.23	8
Tranexamic Acid	\$2,537.70	14					\$2,537.70	14
Aminocaproic Acid	\$162.81	3	\$412.47	3	\$883.41	4	\$1,458.69	10
Anorex., Resp. & Cerebral Stim., Misc.	\$1,143,910.59	6,595	\$1,086,805.96	6,286	\$2,375,377.84	13,883	\$4,606,094.39	26,764
Methylphenidate	\$753,153.35	4,340	\$695,832.45	4,054	\$1,558,134.10	9,091	\$3,007,119.90	17,485
Dexmethylphenidate	\$385,855.65	2,247	\$381,746.08	2,220	\$811,088.93	4,781	\$1,578,690.66	9,248
Modafinil	\$3,550.54	6	\$8,765.78	10	\$5,653.16	5	\$17,969.48	21
Armodafinil	\$1,351.05	2	\$451.65	1	\$451.65	1	\$2,254.35	4
Corticosteroids	\$679,422.27	5,586	\$696,357.99	5,657	\$1,618,889.24	12,620	\$2,994,669.50	23,863
Mometasone Nasal	\$471,132.15	3,553	\$487,822.66	3,635	\$1,164,956.25	8,165	\$2,123,911.06	15,353
Ciprofloxacin-dexamethasone Otic	\$150,073.50	997	\$141,341.14	913	\$296,973.63	1,927	\$588,388.27	3,837
Fluticasone Nasal	\$13,706.14	150	\$26,911.99	290	\$68,403.91	738	\$109,022.04	1,178
Dexamethasone-tobramycin Ophthalmic	\$17,425.86	162	\$16,586.37	145	\$35,015.62	321	\$69,027.85	628
Hydrocortisone/neomycin/polymyxin B	\$9,217.96	398	\$8,257.24	349	\$16,700.95	721	\$34,176.15	1,468
Ciprofloxacin-hydrocortisone Otic	\$5,674.07	35	\$4,453.54	26	\$8,723.05	55	\$18,850.66	116
Ciclesonide Nasal	\$1,429.28	8	\$2,238.12	18	\$6,496.08	50	\$10,163.48	76

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Resource Utilization Report
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	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Hydrocortisone/neomycin/polymyxin B	\$3,104.05	21	\$2,382.67	21	\$4,341.03	38	\$9,827.75	80
Tobramycin Ophthalmic	\$2,046.72	151	\$2,113.35	186	\$5,293.75	425	\$9,453.82	762
Loteprednol Ophthalmic	\$1,317.87	9	\$1,454.58	11	\$4,808.58	30	\$7,581.03	50
Dexamethasone/neomycin/polymyxin B	\$1,998.66	132	\$1,992.07	138	\$5,351.04	338	\$7,351.77	477
Acetic Acid-hydrocortisone Otic	\$1,210.16	8	\$538.67	4	\$2,805.78	18	\$4,554.61	30
Prednisolone Ophthalmic	\$1,107.37	79	\$1,255.88	84	\$2,104.73	147	\$4,467.98	310
Colistin/hc/neomycin/thonzonium Otic	\$920.16	12	\$700.12	10	\$2,077.96	27	\$3,698.24	49
Loteprednol-tobramycin Ophthalmic	\$464.66	2	\$624.85	3	\$1,408.71	9	\$2,498.22	14
Beclomethasone Nasal	\$696.59	4	\$498.98	3	\$1,283.11	8	\$2,478.68	15
Prednisolone-sulfacetamide Sodium Oph	\$187.42	6	\$453.91	8	\$1,828.16	24	\$2,469.49	38
Flunisolide Nasal	\$303.66	1	\$577.05	2	\$607.32	2	\$1,488.03	5
Fluorometholone Ophthalmic	\$167.70	10	\$270.44	11	\$768.96	40	\$1,207.10	61
Bacitracin/neomycin/polymyxin B Ophth	\$471.04	9	\$240.77	6	\$425.64	8	\$1,137.45	23
Triamcinolone Nasal	\$371.58	3	\$123.86	1	\$247.72	2	\$743.16	6
Bacitracin/hc/neomycin/polymyxin B Op	\$71.17	2	\$56.69	1	\$437.95	8	\$522.66	11
Anticonvulsants, Miscellaneous	\$738,157.01	7,038	\$660,169.86	6,339	\$1,463,686.60	13,894	\$2,862,013.47	27,271
Oxcarbazepine	\$119,999.92	918	\$101,670.72	806	\$246,199.86	1,956	\$467,870.50	3,680
Divalproex Sodium	\$115,116.73	1,216	\$104,160.93	1,087	\$230,897.33	2,511	\$450,174.99	4,814
Levetiracetam	\$94,307.16	1,090	\$82,161.33	954	\$169,660.03	2,047	\$346,128.52	4,091
Lacosamide	\$61,311.00	121	\$59,096.48	115	\$136,498.40	247	\$256,905.88	483
Pregabalin	\$61,118.71	264	\$57,650.02	259	\$105,105.23	486	\$223,873.96	1,009
Vigabatrin	\$55,200.75	8	\$40,182.85	3	\$118,792.48	15	\$214,176.08	26

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Drug Class Report
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AHFS Class / Generic Molecule	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Lamotrigine	\$53,472.89	658	\$46,919.62	581	\$102,410.01	1,232	\$202,802.52	2,471
Topiramate	\$43,265.17	757	\$42,435.38	681	\$93,930.93	1,483	\$179,631.48	2,921
Gabapentin	\$41,386.61	1,135	\$38,749.19	1,066	\$75,965.68	2,192	\$156,101.48	4,393
Rufinamide	\$25,889.10	34	\$27,101.11	30	\$47,064.23	57	\$100,054.44	121
Felbamate	\$25,581.10	28	\$20,097.46	21	\$50,905.19	62	\$96,583.75	111
Carbamazepine	\$21,974.75	402	\$18,868.30	356	\$38,518.12	760	\$79,361.17	1,518
Zonisamide	\$9,876.81	222	\$8,434.81	205	\$19,276.49	485	\$37,588.11	912
Valproic Acid	\$7,672.59	170	\$7,816.81	166	\$15,082.91	321	\$30,572.31	657
Tiagabine	\$1,694.10	3	\$4,760.11	6	\$12,326.08	19	\$18,780.29	28
Magnesium Sulfate	\$289.62	12	\$64.74	3	\$1,053.63	21	\$1,407.99	36
Beta-adrenergic Agonists	\$674,507.39	10,795	\$649,214.83	9,891	\$1,386,220.68	20,612	\$2,709,942.90	41,298
Albuterol	\$420,277.53	9,762	\$412,551.10	8,949	\$871,013.14	18,604	\$1,703,841.77	37,315
Fluticasone-salmeterol	\$220,781.42	890	\$206,261.94	797	\$446,831.21	1,713	\$873,874.57	3,400
Albuterol-ipratropium	\$20,266.70	91	\$21,871.19	107	\$45,060.08	221	\$87,197.97	419
Levalbuterol	\$11,277.22	42	\$6,726.08	30	\$19,833.15	58	\$37,836.45	130
Formoterol	\$1,278.77	6	\$1,180.20	6	\$2,697.26	13	\$5,156.23	25
Pirbuterol	\$333.76	2	\$792.79	5	\$1,401.89	9	\$2,528.44	16
Arformoterol	\$614.19	2	\$624.32	2	\$785.84	3	\$2,024.35	7
Central Nervous System Agents, Misc	\$655,509.96	2,862	\$597,266.80	2,679	\$1,312,191.13	5,863	\$2,564,967.89	11,404
Guanfacine	\$448,763.95	2,118	\$427,604.50	2,013	\$936,492.37	4,410	\$1,812,860.82	8,541
Atomoxetine	\$137,734.43	656	\$125,056.73	594	\$271,311.57	1,300	\$534,102.73	2,550

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	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Tetrabenazine	\$46,885.41	6	\$27,472.47	3	\$68,688.55	9	\$143,046.43	18
Memantine	\$11,450.76	65	\$10,559.45	54	\$21,419.60	113	\$43,429.81	232
Dextromethorphan-quinidine	\$6,566.66	16	\$6,573.65	15	\$14,085.67	30	\$27,225.98	61
Sodium Oxybate	\$4,108.75	1					\$4,108.75	1
Cephalosporins	\$547,243.46	8,765	\$543,247.25	8,649	\$957,228.68	16,305	\$2,047,719.39	33,719
Cefdinir	\$370,157.22	4,569	\$384,855.37	4,550	\$647,612.62	7,873	\$1,402,625.21	16,992
Cefprozil	\$97,719.80	1,569	\$91,921.52	1,479	\$179,312.54	2,921	\$368,953.86	5,969
Cephalexin	\$34,474.12	2,019	\$34,048.12	1,970	\$79,709.62	4,463	\$148,231.86	8,452
Ceftriaxone	\$8,073.56	77	\$9,388.62	81	\$15,869.06	180	\$33,331.24	338
Cefuroxime	\$6,325.30	319	\$7,475.19	368	\$13,497.29	605	\$27,297.78	1,292
Cefadroxil	\$7,136.43	130	\$8,073.43	152	\$10,432.76	208	\$25,642.62	490
Cefixime	\$13,563.63	54	\$3,160.90	10	\$3,574.95	13	\$20,299.48	77
Cefepime	\$234.81	3	\$1,863.23	18	\$5,702.68	23	\$7,800.72	44
Ceftaroline	\$6,427.29	3					\$6,427.29	3
Ceftibuten	\$1,151.97	3	\$1,344.89	5	\$574.03	1	\$3,070.89	9
Ceftazidime	\$1,165.65	9	\$153.68	1	\$223.54	2	\$1,542.87	12
Cefaclor	\$309.14	6	\$415.93	8	\$489.25	12	\$1,214.32	26
Cefpodoxime	\$338.79	2	\$211.99	2	\$230.34	4	\$781.12	8
Cefazolin	\$165.75	2	\$334.38	5			\$500.13	7
Antineoplastic Agents	\$448,684.67	882	\$498,849.05	783	\$964,777.13	1,809	\$1,912,310.85	3,474
Everolimus	\$89,932.24	10	\$139,274.80	16	\$261,732.88	32	\$490,939.92	58

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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	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Sunitinib	\$109,408.42	10	\$41,217.70	4	\$136,381.44	12	\$287,007.56	26
Leuprolide	\$65,711.14	44	\$87,608.74	42	\$143,354.40	56	\$278,803.72	142
Erlotinib	\$38,230.76	8	\$51,213.83	9	\$90,853.49	16	\$180,298.08	33
Imatinib	\$41,167.74	7	\$40,885.76	5	\$54,033.12	8	\$136,086.62	20
Megestrol	\$21,028.48	170	\$15,512.36	140	\$32,561.06	294	\$69,101.90	604
Capecitabine	\$8,271.55	3	\$17,095.41	6	\$43,065.92	13	\$68,432.88	22
Letrozole	\$14,748.36	36	\$15,842.06	40	\$31,941.94	78	\$62,532.36	154
Dasatinib			\$9,063.64	1	\$45,318.20	5	\$54,381.84	6
Pazopanib	\$7,530.56	1	\$7,530.56	1	\$37,652.80	5	\$52,713.92	7
Methotrexate	\$12,267.16	380	\$9,703.04	300	\$22,117.32	824	\$44,087.52	1,504
Temozolomide	\$2,868.03	1	\$15,885.08	6	\$21,468.68	12	\$40,221.79	19
Lapatinib			\$17,846.80	4	\$18,507.64	4	\$36,354.44	8
Anastrozole	\$8,260.62	34	\$9,177.32	38	\$15,772.06	70	\$33,210.00	142
Nilotinib	\$8,459.59	1	\$8,459.59	1	\$8,459.59	1	\$25,378.77	3
Bevacizumab			\$5,246.19	1	\$19,674.40	5	\$24,920.59	6
Mercaptopurine	\$2,339.30	27	\$2,488.25	26	\$6,747.95	80	\$11,575.50	133
Hydroxyurea	\$2,872.29	55	\$2,743.58	51	\$5,497.57	102	\$11,113.44	208
Tamoxifen	\$3,234.08	66	\$2,869.50	60	\$4,488.84	98	\$10,592.42	224
Tretinoin	\$7,341.04	2	\$2,815.05	1			\$10,156.09	3
Cabazitaxel			\$8,879.85	1			\$8,879.85	1
Bicalutamide	\$1,279.84	12	\$1,190.44	12	\$4,445.94	44	\$6,916.22	68
Etoposide			\$889.27	1	\$4,446.35	5	\$5,335.62	6

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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	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Mitotane	\$948.16	1	\$948.16	1	\$1,084.38	2	\$2,980.70	4
Exemestane	\$805.44	4	\$1,249.24	6	\$443.80	2	\$2,498.48	12
Thioguanine			\$38.00	1	\$1,833.26	17	\$1,871.26	18
Procarbazine	\$1,532.83	1					\$1,532.83	1
Flutamide			\$857.88	6			\$857.88	6
Cytarabine	\$108.03	6	\$33.63	1	\$672.60	20	\$814.26	27
Proton-pump Inhibitors	\$417,909.47	1,966	\$453,097.26	2,081	\$1,036,547.71	4,767	\$1,907,554.44	8,814
Esomeprazole	\$299,196.39	1,391	\$360,227.78	1,667	\$842,153.46	3,899	\$1,204,830.23	5,573
Lansoprazole	\$52,528.75	238	\$35,184.67	153	\$61,796.77	276	\$149,510.19	667
Rabeprazole	\$25,225.15	83	\$31,750.29	104	\$73,575.90	240	\$130,551.34	427
Pantoprazole	\$15,534.61	90	\$12,188.56	70	\$21,864.73	140	\$49,587.90	300
Amoxicillin/clarithromycin/lansoprazole	\$11,049.34	25	\$6,839.11	16	\$20,042.82	39	\$37,931.27	80
Dexlansoprazole	\$8,186.72	53	\$3,829.67	26	\$8,076.70	48	\$20,093.09	127
Omeprazole	\$6,188.51	86	\$3,077.18	45	\$9,037.33	125	\$18,303.02	256
Biologic Response Modifiers	\$461,835.80	68	\$367,922.93	55	\$1,077,663.77	141	\$1,907,422.50	264
Lenalidomide	\$146,341.40	16	\$181,438.72	20	\$505,472.78	54	\$833,252.90	90
Interferon Beta-1a	\$122,652.23	27	\$67,754.61	16	\$204,393.43	42	\$394,800.27	85
Interferon Gamma-1b	\$20,051.01	1	\$40,102.02	2	\$200,510.10	10	\$260,663.13	13
Glatiramer	\$47,762.48	10	\$48,638.50	10	\$145,927.50	30	\$242,328.48	50
Thalidomide	\$103,668.72	9					\$103,668.72	9
Natalizumab	\$17,045.40	4	\$17,045.40	4	\$17,045.40	4	\$51,136.20	12

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

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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	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Interferon Beta-1b	\$4,314.56	1	\$12,943.68	3	\$4,314.56	1	\$21,572.80	5
Leukotriene Modifiers	\$513,425.31	3,059	\$442,052.93	2,632	\$948,955.78	5,663	\$1,904,434.02	11,354
Montelukast	\$731,447.25	4,349	\$710,857.46	4,216	\$1,810,933.30	10,738	\$3,253,238.01	19,303
Zafirlukast	\$175.22	2	\$309.13	3	\$211.68	2	\$520.81	5
Insulins	\$444,400.52	1,870	\$407,266.33	1,720	\$798,150.03	3,460	\$1,649,816.88	7,050
Insulin Aspart	\$145,344.34	509	\$132,449.65	462	\$260,299.74	894	\$538,093.73	1,865
Insulin Glargine	\$118,738.23	520	\$115,015.67	485	\$228,949.79	1,025	\$462,703.69	2,030
Insulin Detemir	\$47,773.84	191	\$44,202.73	185	\$95,399.08	415	\$187,375.65	791
Insulin Aspart-insulin Aspart Protamine	\$47,265.31	121	\$42,197.88	99	\$83,499.88	234	\$172,963.07	454
Insulin Isophane	\$23,427.90	194	\$22,373.67	193	\$40,222.78	369	\$86,024.35	756
Insulin Isophane-insulin Regular	\$25,699.61	124	\$22,443.52	112	\$36,796.15	176	\$84,939.28	412
Insulin Lispro	\$17,593.98	71	\$15,423.28	64	\$25,500.00	129	\$58,517.26	264
Insulin Regular	\$13,856.80	126	\$9,874.34	109	\$17,495.98	185	\$41,227.12	420
Insulin Lispro-insulin Lispro Protamine	\$3,451.10	9	\$2,670.84	7	\$5,787.95	17	\$11,909.89	33
Insulin Glulisine	\$1,249.41	5	\$614.75	4	\$4,198.68	16	\$6,062.84	25

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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	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Budesonide	\$1,495,510.04	3,324	\$1,407,359.08	3,098	\$3,093,003.08	6,746	\$5,995,872.20	13,168
Pulmicort Respules	\$1,457,425.42	3,182	\$1,365,951.40	2,938	\$2,976,294.44	6,386	\$5,799,671.26	12,506
Lisdexamfetamine	\$829,014.28	4,608	\$814,391.21	4,514	\$1,820,705.25	10,125	\$3,464,110.74	19,247
Vyvanse	\$829,014.28	4,608	\$814,391.21	4,514	\$1,820,705.25	10,125	\$3,464,110.74	19,247
Montelukast	\$731,447.25	4,349	\$710,857.46	4,216	\$1,810,933.30	10,738	\$3,253,238.01	19,303
Singulair	\$731,447.25	4,349	\$710,857.46	4,216	\$1,810,933.30	10,738	\$3,253,238.01	19,303
Singulair	\$509,118.83	3,023	\$438,801.55	2,606	\$943,284.43	5,615	\$1,891,204.81	11,244
Aripiprazole	\$887,655.01	1,252	\$773,979.73	1,132	\$1,507,999.33	2,449	\$3,169,634.07	4,833
Abilify	\$883,049.90	1,247	\$771,640.37	1,129	\$1,500,935.25	2,441	\$3,155,625.52	4,817
Methylphenidate	\$753,153.35	4,340	\$695,832.45	4,054	\$1,558,134.10	9,091	\$3,007,119.90	17,485
Methylphenidate Hydrochloride Er	\$614,296.34	3,279	\$565,864.39	3,073	\$1,278,229.93	6,910	\$2,458,390.66	13,262
Amphetamine-dextroamphetamine	\$596,550.44	3,785	\$605,491.58	3,767	\$1,294,721.74	8,281	\$2,496,763.76	15,833
Adderall Xr	\$465,771.53	1,934	\$471,304.33	1,969	\$981,753.81	4,109	\$1,918,829.67	8,012
Antihemophilic Factor	\$528,152.62	26	\$311,958.12	10	\$1,590,309.96	60	\$2,430,420.70	96
Advate Rahf-pfm	\$275,113.65	9	\$245,351.11	5	\$1,000,009.40	15	\$1,520,474.16	29
Mometasone Nasal	\$471,132.15	3,553	\$487,822.66	3,635	\$1,164,956.25	8,165	\$2,123,911.06	15,353

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

Generic Molecule / Drug Name	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Nasonex	\$471,132.15	3,553	\$487,822.66	3,635	\$1,164,956.25	8,165	\$2,123,911.06	15,353
Oseltamivir	\$862,429.52	4,995	\$534,151.95	2,942	\$619,856.39	5,483	\$2,016,437.86	11,647
Tamiflu	\$862,429.52	4,995	\$534,151.95	2,942	\$619,856.39	3,710	\$2,016,437.86	11,647
Tamiflu	\$288,343.86	2,576	\$276,462.90	2,516	\$562,650.13	5,483	\$1,127,456.89	10,575
Guanfacine	\$448,763.95	2,118	\$427,604.50	2,013	\$936,492.37	4,410	\$1,812,860.82	8,541
Intuniv	\$448,763.95	2,118	\$427,604.50	2,013	\$936,492.37	4,410	\$1,812,860.82	8,541
Albuterol	\$420,277.53	9,762	\$412,551.10	8,949	\$871,013.14	18,604	\$1,703,841.77	37,315
Proventil Hfa	\$161,382.51	2,598	\$249,887.81	3,903	\$566,607.34	8,950	\$977,877.66	15,451
Dexmethylphenidate	\$385,855.65	2,247	\$381,746.08	2,220	\$811,088.93	4,781	\$1,578,690.66	9,248
Focalin Xr	\$368,348.65	1,813	\$365,239.54	1,811	\$772,795.45	3,816	\$1,506,383.64	7,440
Quetiapine	\$406,011.80	1,087	\$363,166.89	951	\$804,695.59	2,249	\$1,573,874.28	4,287
Quetiapine Fumarate	\$199,785.95	611	\$186,516.20	559	\$382,931.46	1,231	\$769,233.61	2,401
Azithromycin	\$384,942.34	12,132	\$399,768.76	12,566	\$639,348.20	20,116	\$1,424,059.30	44,814
Azithromycin	\$316,986.20	9,222	\$327,632.54	9,470	\$534,331.04	15,587	\$1,178,949.78	34,279
Cefdinir	\$370,157.22	4,569	\$384,855.37	4,550	\$647,612.62	7,873	\$1,402,625.21	16,992
Cefdinir	\$370,157.22	4,569	\$384,855.37	4,550	\$647,612.62	7,873	\$1,402,625.21	16,992
Esomeprazole	\$299,196.39	1,391	\$360,227.78	1,667	\$842,153.46	3,899	\$1,204,830.23	5,573
Nexium	\$2,448.99	7	\$360,227.78	1,667	\$842,153.46	3,899	\$1,204,830.23	5,573
Cetirizine	\$308,752.06	12,262	\$279,015.32	11,831	\$591,630.57	27,328	\$1,179,397.95	51,421

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

Generic Molecule / Drug Name	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Cetirizine Hydrochloride	\$307,595.12	12,118	\$277,672.18	11,683	\$588,144.85	26,873	\$1,173,412.15	50,674
Palivizumab	\$395,720.38	199	\$301,730.86	160	\$477,870.35	222	\$1,175,321.59	581
Synagis	\$395,720.38	199	\$301,730.86	160	\$477,870.35	222	\$1,175,321.59	581
Anti-inhibitor Coagulant Complex	\$588,035.57	5	\$330,209.03	2	\$185,032.69	1	\$1,103,277.29	8
Feiba Nf	\$588,035.57	5	\$330,209.03	2	\$185,032.69	1	\$1,103,277.29	8
Ondansetron	\$217,562.66	2,171	\$241,761.33	2,356	\$620,199.41	5,897	\$1,079,523.40	10,424
Ondansetron Hydrochloride	\$217,562.66	2,171	\$241,761.33	2,356	\$620,199.41	5,897	\$1,079,523.40	10,424
Risperidone	\$247,216.65	2,707	\$222,887.02	2,491	\$510,519.84	5,607	\$980,623.51	10,805
Risperidone	\$238,218.47	2,692	\$218,970.10	2,484	\$496,755.47	5,589	\$953,944.04	10,765
Fluticasone-salmeterol	\$220,781.42	890	\$206,261.94	797	\$446,831.21	1,713	\$873,874.57	3,400
Advair Diskus	\$194,064.91	795	\$182,710.56	715	\$392,038.47	1,520	\$768,813.94	3,030
Lenalidomide	\$146,341.40	16	\$181,438.72	20	\$505,472.78	54	\$833,252.90	90
Revlimid	\$146,341.40	16	\$181,438.72	20	\$505,472.78	54	\$833,252.90	90
Medroxyprogesterone	\$229,907.34	5,943	\$179,602.26	4,563	\$379,482.72	9,165	\$788,992.32	19,671
Medroxyprogesterone Acetate	\$226,558.80	5,832	\$177,337.44	4,488	\$379,318.20	9,156	\$783,214.44	19,476

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

AHFS Class / Generic Molecule	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Penicillins	\$383,044.09	17,583	\$404,061.91	18,087	\$797,140.19	35,185	\$1,584,246.19	70,855
Amoxicillin	\$136,805.18	12,565	\$143,330.05	12,932	\$268,440.22	24,625	\$548,575.45	50,122
Amoxicillin-clavulanate	\$232,563.18	4,043	\$246,955.87	4,168	\$496,835.81	8,458	\$839,009.48	14,099
Penicillin V Potassium	\$10,268.41	906	\$9,537.45	880	\$20,806.44	1,876	\$40,612.30	3,662
Second Generation Antihistamines	\$331,590.23	14,610	\$302,119.05	14,114	\$641,400.26	32,312	\$1,275,109.54	61,036
Cetirizine	\$308,752.06	12,262	\$279,015.32	11,831	\$591,630.57	27,328	\$1,179,397.95	51,421
Loratadine	\$12,471.51	1,803	\$11,425.78	1,674	\$26,678.59	3,892	\$50,575.88	7,369
Cetirizine-pseudoephedrine	\$7,492.46	418	\$8,804.48	486	\$16,423.84	877	\$32,720.78	1,781
Antitussives	\$125,828.83	15,158	\$132,425.74	15,624	\$213,622.09	25,376	\$471,876.66	56,158
Brompheniramine/dextromethorph/phe	\$87,081.79	9,460	\$95,751.09	10,348	\$153,874.83	16,532	\$336,707.71	36,340
Codeine-guaifenesin	\$16,015.99	2,878	\$15,060.12	2,655	\$25,173.84	4,594	\$56,249.95	10,127
Dextromethorphan-guaifenesin	\$7,293.06	1,279	\$6,401.95	1,142	\$9,312.01	1,690	\$23,007.02	4,111
Benzonatate	\$6,233.51	716	\$5,715.53	625	\$10,864.54	1,236	\$22,813.58	2,577
Nitrofurantoin	\$39,369.14	530	\$36,297.25	548	\$93,046.19	1,204	\$168,712.58	2,282
Dextromethorphan	\$7,245.59	614	\$6,944.38	582	\$10,211.25	877	\$24,401.22	2,073
Adrenals	\$1,805,384.68	12,710	\$1,711,776.07	12,596	\$3,727,823.22	24,684	\$7,244,983.97	49,990
Prednisolone	\$98,860.89	5,983	\$103,894.73	5,970	\$202,326.03	10,761	\$405,081.65	22,714

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 Number of Claims*†

AHFS Class / Generic Molecule	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Budesonide	\$1,495,510.04	3,324	\$1,407,359.08	3,098	\$3,093,003.08	6,746	\$5,995,872.20	13,168
Prednisone	\$6,756.40	1,205	\$7,544.05	1,358	\$14,820.33	2,668	\$29,120.78	5,231
Methylprednisolone	\$8,174.84	619	\$8,546.11	644	\$16,612.12	1,248	\$33,333.07	2,511
Fluticasone	\$67,284.46	448	\$61,918.76	415	\$144,573.23	956	\$273,776.45	1,819
Beclomethasone	\$40,414.37	295	\$40,212.00	294	\$86,227.44	637	\$166,853.81	1,226
Dexamethasone	\$3,876.21	310	\$3,331.39	312	\$6,791.24	601	\$13,998.84	1,223
Mometasone	\$25,778.13	181	\$26,000.62	185	\$44,334.66	320	\$96,113.41	686
Budesonide-formoterol	\$39,189.13	170	\$33,742.04	148	\$82,905.43	358	\$155,836.60	676
Macrolides	\$434,769.68	12,927	\$452,478.37	13,376	\$725,879.19	21,413	\$1,613,127.24	47,716
Azithromycin	\$384,942.34	12,132	\$399,768.76	12,566	\$639,348.20	20,116	\$1,424,059.30	44,814
Clarithromycin	\$45,180.29	743	\$49,238.63	776	\$78,138.19	1,213	\$172,557.11	2,732
Beta-adrenergic Agonists	\$674,507.39	10,795	\$649,214.83	9,891	\$1,386,220.68	20,612	\$2,709,942.90	41,298
Albuterol	\$420,277.53	9,762	\$412,551.10	8,949	\$871,013.14	18,604	\$1,703,841.77	37,315
Fluticasone-salmeterol	\$220,781.42	890	\$206,261.94	797	\$446,831.21	1,713	\$873,874.57	3,400
Nonsteroidal Anti-inflammatory Agen	\$102,548.47	10,241	\$93,514.76	9,452	\$181,615.62	18,259	\$377,678.85	37,952
Ibuprofen	\$63,704.90	6,165	\$56,446.19	5,526	\$101,708.85	10,119	\$221,859.94	21,810
Aspirin	\$5,676.64	1,736	\$5,650.40	1,692	\$10,622.56	3,388	\$21,949.60	6,816
Naproxen	\$17,407.44	1,245	\$16,362.58	1,200	\$38,814.55	2,592	\$72,584.57	5,037
Meloxicam	\$4,753.37	576	\$4,561.75	571	\$8,653.58	1,095	\$17,968.70	2,242
Apap/butalbital/caffeine	\$10,864.69	467	\$10,325.46	452	\$23,326.06	1,000	\$44,516.21	1,919
Ketorolac	\$2,517.42	205	\$2,179.02	178	\$5,403.22	450	\$10,099.66	833

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

AHFS Class / Generic Molecule	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Diclofenac	\$3,651.41	159	\$3,286.03	133	\$6,802.03	307	\$13,739.47	599
Opiate Agonists	\$199,620.70	9,884	\$173,604.19	8,693	\$396,506.63	18,455	\$769,731.52	37,032
Acetaminophen-hydrocodone	\$84,037.62	5,796	\$74,556.79	5,050	\$143,725.79	10,300	\$302,320.20	21,146
Acetaminophen-codeine	\$18,188.56	2,193	\$16,691.69	2,055	\$36,579.65	4,511	\$71,459.90	8,759
Acetaminophen-oxycodone	\$21,042.90	640	\$16,475.74	545	\$34,144.41	1,264	\$71,663.05	2,449
Tramadol	\$2,873.50	540	\$2,332.04	441	\$5,596.46	1,028	\$9,041.37	1,657
Fentanyl	\$45,426.62	208	\$38,721.12	140	\$126,709.69	299	\$210,857.43	647
Amphetamines	\$1,460,203.97	8,576	\$1,453,366.36	8,466	\$3,194,171.23	18,833	\$6,107,741.56	35,875
Lisdexamfetamine	\$829,014.28	4,608	\$814,391.21	4,514	\$1,820,705.25	10,125	\$3,464,110.74	19,247
Amphetamine-dextroamphetamine	\$596,550.44	3,785	\$605,491.58	3,767	\$1,294,721.74	8,281	\$2,496,763.76	15,833
Dextroamphetamine	\$34,639.25	183	\$33,483.57	185	\$78,744.24	427	\$146,867.06	795
Cephalosporins	\$547,243.46	8,765	\$543,247.25	8,649	\$957,228.68	16,305	\$2,047,719.39	33,719
Cefdinir	\$370,157.22	4,569	\$384,855.37	4,550	\$647,612.62	7,873	\$1,402,625.21	16,992
Cephalexin	\$34,474.12	2,019	\$34,048.12	1,970	\$79,709.62	4,463	\$148,231.86	8,452
Cefprozil	\$97,719.80	1,569	\$91,921.52	1,479	\$179,312.54	2,921	\$368,953.86	5,969
Cefuroxime	\$6,325.30	319	\$7,475.19	368	\$13,497.29	605	\$27,297.78	1,292
Sulfonamides	\$107,097.06	7,639	\$98,132.46	7,018	\$193,597.00	14,124	\$398,826.52	28,781
Sulfamethoxazole-trimethoprim	\$105,651.34	7,604	\$97,579.96	6,992	\$192,765.02	14,070	\$395,996.32	28,666
Anticonvulsants, Miscellaneous	\$738,157.01	7,038	\$660,169.86	6,339	\$1,463,686.60	13,894	\$2,862,013.47	27,271
Divalproex Sodium	\$115,116.73	1,216	\$104,160.93	1,087	\$230,897.33	2,511	\$450,174.99	4,814

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

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

AHFS Class / Generic Molecule	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Gabapentin	\$41,386.61	1,135	\$38,749.19	1,066	\$75,965.68	2,192	\$156,101.48	4,393
Levetiracetam	\$94,307.16	1,090	\$82,161.33	954	\$169,660.03	2,047	\$346,128.52	4,091
Oxcarbazepine	\$119,999.92	918	\$101,670.72	806	\$246,199.86	1,956	\$467,870.50	3,680
Topiramate	\$43,265.17	757	\$42,435.38	681	\$93,930.93	1,483	\$179,631.48	2,921
Lamotrigine	\$53,472.89	658	\$46,919.62	581	\$102,410.01	1,232	\$202,802.52	2,471
Carbamazepine	\$21,974.75	402	\$18,868.30	356	\$38,518.12	760	\$79,361.17	1,518
Pregabalin	\$61,118.71	264	\$57,650.02	259	\$105,105.23	486	\$223,873.96	1,009
Zonisamide	\$9,876.81	222	\$8,434.81	205	\$19,276.49	485	\$37,588.11	912
Valproic Acid	\$7,672.59	170	\$7,816.81	166	\$15,082.91	321	\$30,572.31	657
Anorex., Resp. & Cerebral Stim., Misc.	\$1,143,910.59	6,595	\$1,086,805.96	6,286	\$2,375,377.84	13,883	\$4,606,094.39	26,764
Methylphenidate	\$753,153.35	4,340	\$695,832.45	4,054	\$1,558,134.10	9,091	\$3,007,119.90	17,485
Dexmethylphenidate	\$385,855.65	2,247	\$381,746.08	2,220	\$811,088.93	4,781	\$1,578,690.66	9,248
Antipsychotics (atypical And Typical)	\$1,907,846.93	6,338	\$1,706,182.90	5,765	\$3,598,355.15	12,981	\$7,212,384.98	25,084
Risperidone	\$247,216.65	2,707	\$222,887.02	2,491	\$510,519.84	5,607	\$980,623.51	10,805
Aripiprazole	\$887,655.01	1,252	\$773,979.73	1,132	\$1,507,999.33	2,449	\$3,169,634.07	4,833
Quetiapine	\$406,011.80	1,087	\$363,166.89	951	\$804,695.59	2,249	\$1,573,874.28	4,287
Olanzapine	\$183,243.71	344	\$178,407.12	330	\$397,335.26	716	\$758,986.09	1,390
Haloperidol	\$10,329.55	261	\$9,923.30	242	\$19,114.88	534	\$39,367.73	1,037
Corticosteroids	\$679,422.27	5,586	\$696,357.99	5,657	\$1,618,889.24	12,620	\$2,994,669.50	23,863
Mometasone Nasal	\$471,132.15	3,553	\$487,822.66	3,635	\$1,164,956.25	8,165	\$2,123,911.06	15,353
Ciprofloxacin-dexamethasone Otic	\$150,073.50	997	\$141,341.14	913	\$296,973.63	1,927	\$588,388.27	3,837

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

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

AHFS Class / Generic Molecule	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Hydrocortisone/neomycin/polymyxin B	\$9,217.96	398	\$8,257.24	349	\$16,700.95	721	\$34,176.15	1,468
Fluticasone Nasal	\$13,706.14	150	\$26,911.99	290	\$68,403.91	738	\$109,022.04	1,178
Tobramycin Ophthalmic	\$2,046.72	151	\$2,113.35	186	\$5,293.75	425	\$9,453.82	762
Dexamethasone-tobramycin Ophthalmic	\$17,425.86	162	\$16,586.37	145	\$35,015.62	321	\$69,027.85	628

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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	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Cetirizine	\$308,752.06	12,262	\$279,015.32	11,831	\$591,630.57	27,328	\$1,179,397.95	51,421
Cetirizine Hydrochloride	\$307,595.12	12,118	\$277,672.18	11,683	\$588,144.85	26,873	\$1,173,412.15	50,674
Amoxicillin	\$136,805.18	12,565	\$143,330.05	12,932	\$268,440.22	24,625	\$548,575.45	50,122
Amoxicillin	\$136,489.42	12,563	\$143,172.17	12,931	\$268,440.22	24,625	\$548,101.81	50,119
Azithromycin	\$384,942.34	12,132	\$399,768.76	12,566	\$639,348.20	20,116	\$1,424,059.30	44,814
Azithromycin	\$316,986.20	9,222	\$327,632.54	9,470	\$534,331.04	15,587	\$1,178,949.78	34,279
Azithromycin 5 Day Dose Pack	\$64,217.14	2,769	\$68,706.23	2,975	\$99,371.28	4,311	\$232,294.65	10,055
Albuterol	\$420,277.53	9,762	\$412,551.10	8,949	\$871,013.14	18,604	\$1,703,841.77	37,315
Albuterol Sulfate	\$192,504.34	5,826	\$161,360.59	4,999	\$302,065.53	9,566	\$655,930.46	20,391
Proventil Hfa	\$161,382.51	2,598	\$249,887.81	3,903	\$566,607.34	8,950	\$977,877.66	15,451
Brompheniramine/dextromethorph/p	\$87,081.79	9,460	\$95,751.09	10,348	\$153,874.83	16,532	\$336,707.71	36,340
Rynex Dm	\$84,790.26	9,138	\$93,036.94	9,971	\$150,124.46	15,987	\$327,951.66	35,096
Sulfamethoxazole-trimethoprim	\$105,651.34	7,604	\$97,579.96	6,992	\$192,765.02	14,070	\$395,996.32	28,666
Sulfamethoxazole-trimethoprim	\$79,459.90	4,874	\$73,908.86	4,502	\$140,751.30	8,724	\$294,120.06	18,100
Sulfamethoxazole-trimethoprim Ds	\$25,614.76	2,666	\$22,962.48	2,416	\$50,094.48	5,162	\$98,671.72	10,244
Prednisolone	\$98,860.89	5,983	\$103,894.73	5,970	\$202,326.03	10,761	\$405,081.65	22,714

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

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

Generic Molecule / Drug Name	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Prednisolone Sodium Phosphate	\$30,080.37	2,333	\$35,929.92	2,394	\$65,566.42	4,375	\$131,576.71	9,102
Prednisolone	\$18,892.27	2,229	\$19,633.29	2,277	\$35,580.84	4,112	\$74,106.40	8,618
Promethazine	\$51,906.52	4,810	\$55,374.10	5,072	\$125,473.72	11,936	\$232,754.34	21,818
Promethazine Hydrochloride	\$46,293.04	4,436	\$2,502.92	206	\$116,083.40	11,214	\$164,879.36	15,856
Ibuprofen	\$63,704.90	6,165	\$56,446.19	5,526	\$101,708.85	10,119	\$221,859.94	21,810
Ibuprofen	\$56,969.41	5,152	\$49,894.45	4,544	\$90,265.66	8,381	\$197,129.52	18,077
Acetaminophen-hydrocodone	\$84,037.62	5,796	\$74,556.79	5,050	\$143,725.79	10,300	\$302,320.20	21,146
Acetaminophen-hydrocodone Bitartrate	\$84,031.38	5,795	\$74,540.71	5,049	\$143,664.43	10,299	\$302,236.52	21,143
Medroxyprogesterone	\$229,907.34	5,943	\$179,602.26	4,563	\$379,482.72	9,165	\$788,992.32	19,671
Medroxyprogesterone Acetate	\$226,558.80	5,832	\$177,337.44	4,488	\$379,318.20	9,156	\$783,214.44	19,476
Montelukast	\$731,447.25	4,349	\$710,857.46	4,216	\$1,810,933.30	10,738	\$3,253,238.01	19,303
Singulair	\$731,447.25	4,349	\$710,857.46	4,216	\$1,810,933.30	10,738	\$3,253,238.01	19,303
Singulair	\$509,118.83	3,023	\$438,801.55	2,606	\$943,284.43	5,615	\$1,891,204.81	11,244
Lisdexamfetamine	\$829,014.28	4,608	\$814,391.21	4,514	\$1,820,705.25	10,125	\$3,464,110.74	19,247
Vyvanse	\$829,014.28	4,608	\$814,391.21	4,514	\$1,820,705.25	10,125	\$3,464,110.74	19,247
Methylphenidate	\$753,153.35	4,340	\$695,832.45	4,054	\$1,558,134.10	9,091	\$3,007,119.90	17,485
Methylphenidate Hydrochloride Er	\$614,296.34	3,279	\$565,864.39	3,073	\$1,278,229.93	6,910	\$2,458,390.66	13,262
Diphenhydramine	\$21,642.16	4,480	\$20,577.48	4,244	\$42,448.64	8,716	\$84,668.28	17,440
Q-dryl	\$11,905.36	2,416	\$11,828.00	2,364	\$25,090.12	4,984	\$48,823.48	9,764

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

Generic Molecule / Drug Name	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Cefdinir	\$370,157.22	4,569	\$384,855.37	4,550	\$647,612.62	7,873	\$1,402,625.21	16,992
Cefdinir	\$370,157.22	4,569	\$384,855.37	4,550	\$647,612.62	7,873	\$1,402,625.21	16,992
Mometasone Nasal	\$471,132.15	3,553	\$487,822.66	3,635	\$1,164,956.25	8,165	\$2,123,911.06	15,353
Nasonex	\$471,132.15	3,553	\$487,822.66	3,635	\$1,164,956.25	8,165	\$2,123,911.06	15,353
Amoxicillin-clavulanate	\$232,563.18	4,043	\$246,955.87	4,168	\$496,835.81	8,458	\$839,009.48	14,099
Amoxicillin-clavulanate	\$92,336.98	1,453	\$86,937.93	1,368	\$495,677.43	8,446	\$674,952.34	11,267
Amoxicillin-clavulanate	\$232,128.16	4,037	\$246,709.88	4,165	\$166,379.19	2,555	\$645,217.23	10,757
Budesonide	\$1,495,510.04	3,324	\$1,407,359.08	3,098	\$3,093,003.08	6,746	\$5,995,872.20	13,168
Pulmicort Respules	\$1,457,425.42	3,182	\$1,365,951.40	2,938	\$2,976,294.44	6,386	\$5,799,671.26	12,506
Oseltamivir	\$862,429.52	4,995	\$534,151.95	2,942	\$619,856.39	5,483	\$2,016,437.86	11,647
Tamiflu	\$862,429.52	4,995	\$534,151.95	2,942	\$619,856.39	3,710	\$2,016,437.86	11,647
Tamiflu	\$288,343.86	2,576	\$276,462.90	2,516	\$562,650.13	5,483	\$1,127,456.89	10,575
Risperidone	\$247,216.65	2,707	\$222,887.02	2,491	\$510,519.84	5,607	\$980,623.51	10,805
Risperidone	\$238,218.47	2,692	\$218,970.10	2,484	\$496,755.47	5,589	\$953,944.04	10,765
Ondansetron	\$217,562.66	2,171	\$241,761.33	2,356	\$620,199.41	5,897	\$1,079,523.40	10,424
Ondansetron Hydrochloride	\$217,562.66	2,171	\$241,761.33	2,356	\$620,199.41	5,897	\$1,079,523.40	10,424
Codeine-guaifenesin	\$16,015.99	2,878	\$15,060.12	2,655	\$25,173.84	4,594	\$56,249.95	10,127
Cheratussin Ac	\$13,942.67	2,651	\$13,208.67	2,439	\$21,882.37	4,132	\$49,033.71	9,222
Brompheniramine-phenylephrine	\$21,181.22	2,460	\$22,310.08	2,557	\$37,089.82	4,227	\$80,581.12	9,244

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	January 2013		February 2013		March 2013		Quarter	
	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims	Total Paid*	Total Claims
Rynex Pe	\$21,181.22	2,460	\$22,310.08	2,557	\$37,089.82	4,227	\$80,581.12	9,244
Acetaminophen-codeine	\$18,188.56	2,193	\$16,691.69	2,055	\$36,579.65	4,511	\$71,459.90	8,759
Acetaminophen-codeine Phosphate	\$18,188.56	2,193	\$16,691.69	2,055	\$36,579.65	4,511	\$71,459.90	8,759

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

Synagis® (palivizumab) Summary
2012-2013 RSV Season

Description	RSV Season			
	2009-2010	2010-2011	2011-2012	2012-2013
Total Reimbursement*	\$5,055,035	\$4,679,821	\$5,271,331	\$2,397,305
Total Unique Beneficiaries	872	944	812	489
Total Point-of-Sale Claims	3,198	2,736	2,741	1,183
Average Reimbursement* per Beneficiary	\$8,832±\$4,908	\$7,965±\$4,969	\$9,909±\$5,685	\$10,626±9,762
Average Reimbursement* per Injection	\$2,074±\$931	\$2,152±\$956	\$2,388±\$1,075	\$2,730±\$2,431

Figure 1 - Synagis® (palivizumab) Paid Claims*

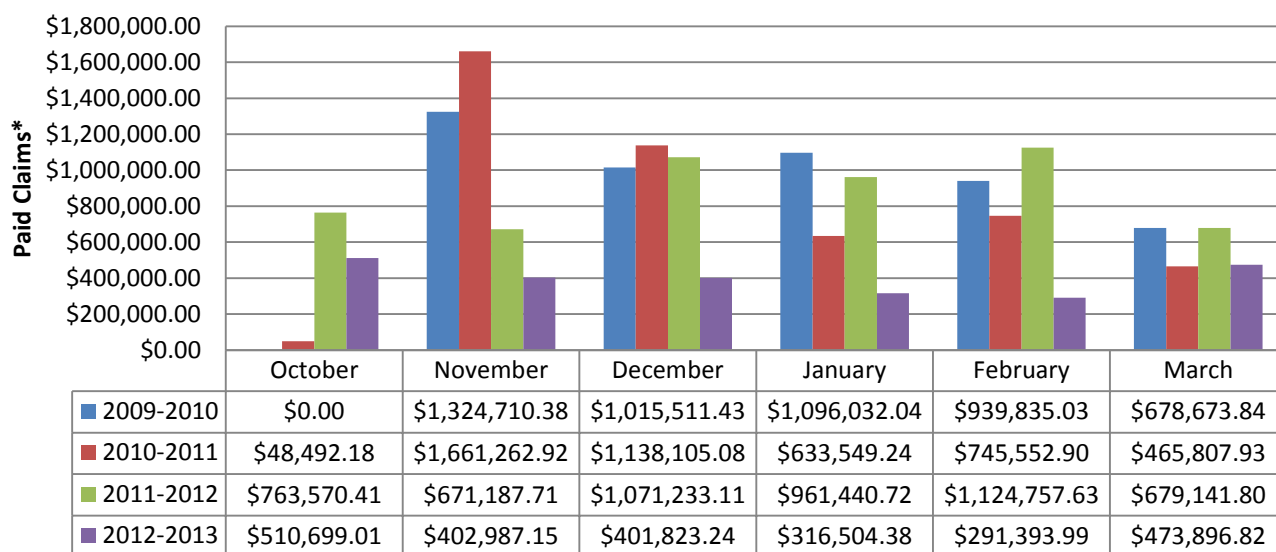


Figure 2 - Synagis® (palivizumab) Count of Injections per Beneficiary

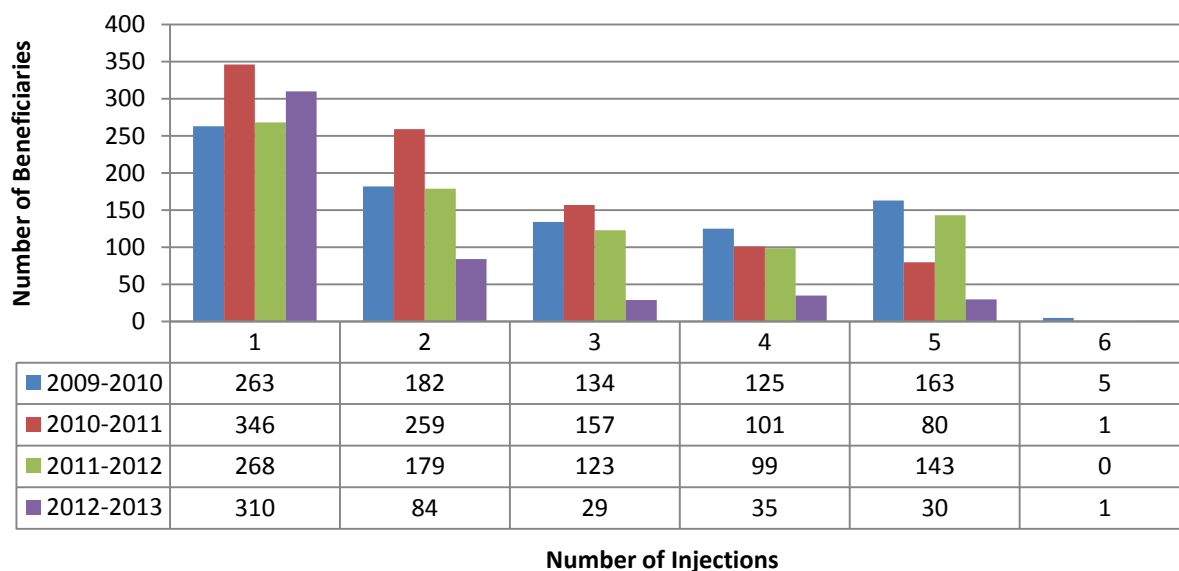
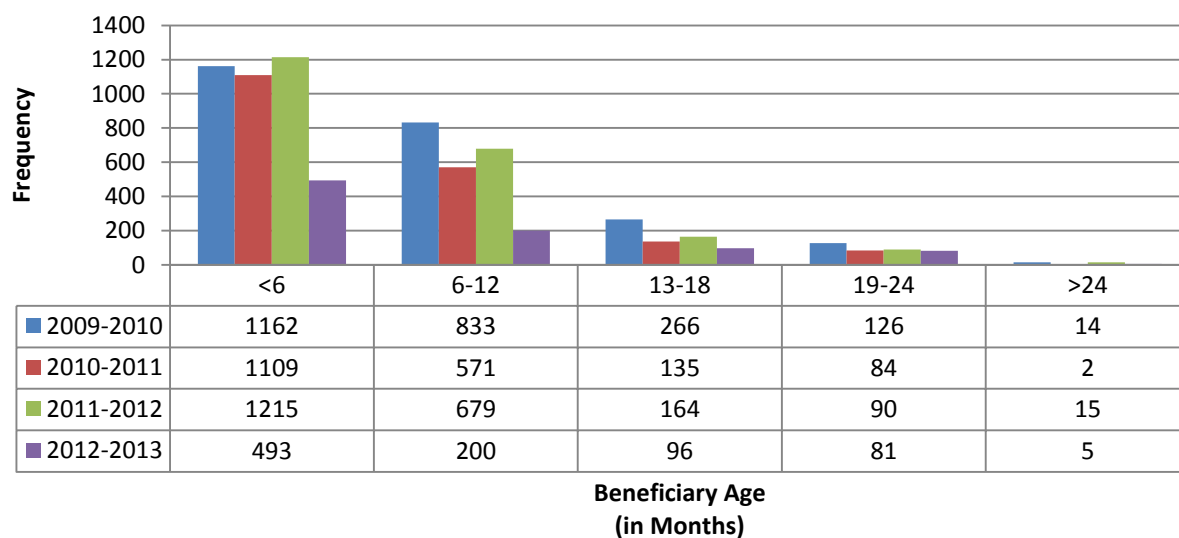


Figure 3 - Estimated Age of Beneficiaries at the Time of Each Synagis® (palivizumab) Injection



Pharmacy Program Update

Special Analysis Projects

DUR ACTIVITIES TO IDENTIFY POTENTIAL DRUG ABUSE AND DIVERSION CASES

BACKGROUND

Drug abuse and diversion are critical issues and have always been an important topic for DUR activities. At this time, the Centers for Medicare and Medicaid Services (CMS) is making a push to strengthen efforts to detect and reduce drug abuse and drug diversion in Medicaid programs.

Last year, MS-DUR asked the DUR Board to review criteria for detecting beneficiaries who were potential drug abusers and/or were diverting drugs using criteria of having a high number of narcotic prescriptions and providers (both pharmacies and prescribers). As was reported to the Board last year, a list of beneficiaries meeting the criteria selected by the Board was turned over to the Division of Medicaid (DOM) Program Integrity Bureau for consideration for the lock-in program.

Prescription Monitoring Program (PMP): Recently DOM and MS-DUR have negotiated an agreement with the Mississippi Prescription Monitoring Program to obtain a copy of their data file for linking to DOM prescription information. The linked data will be used to evaluate the potential problem caused by DUR data not including cash prescriptions for narcotics and to better identify beneficiaries that may need to be moved to the lock-in program. As in the past, MS-DUR will develop lists of beneficiaries for further evaluation by the Program Integrity Bureau.

Over-Compliance with Narcotics: In April, MS-DUR completed an analysis of compliance rates among beneficiaries taking narcotics for more than 90 days. Over-compliant beneficiaries (those with Medication Possession Ratios > 100%) were identified. Over-compliance can only occur when a beneficiary repeatedly refills their prescription early and obtains more medication over time than was indicated by the prescription. This list has been turned over to Program Integrity for further investigation and consideration for inclusion in the lock-in program.

DUR BOARD ACTION REQUESTED TODAY

Discussion and recommendations about:

1. The appropriateness of using over-compliance as an indicator of possible drug abuse or diversion,
2. Other potential indicators that could be used to identify potential problems with beneficiaries or providers.

USE OF CONTROLLED SUBSTANCES IN THE MISSISSIPPI MEDICAID FEE-FOR-SERVICE POPULATION

BACKGROUND

In their report entitled “Usage of Controlled Substance Pain Medications in Medicaid”, Special Needs Consulting Services (SNCS) evaluated the volume of prescriptions for controlled substances in the Medicaid fee-for-service (FFS) population. According to the report, there were 319,940 prescriptions for controlled substances in 2010 among Mississippi Medicaid enrollees aged 15-64 years accounting for 1.55 prescriptions per beneficiary. While the report provides useful information about the use of controlled substances in Mississippi Medicaid, a limitation of their methodology was that they used two different sources of data, namely, State Drug Utilization Data and Medicaid Statistics Information System (MSIS) in the study, which cannot be linked together by a beneficiary identification number. As a result, their estimate of number of scripts per person per year could be misleading. In addition, the measure of number of prescriptions for controlled substance pain medications per person per year does not give a true picture of the appropriate and inappropriate use of these drugs.

MS-DUR examined the use of controlled substance pain medications among Mississippi Medicaid fee-for-service enrollees. In addition, the extent of inappropriate use of these medications was determined using a set of potential quality indicators, namely, proportion of beneficiaries who had a prescription for controlled substance pain medications, number of prescriptions per beneficiary among beneficiaries who had a prescription for controlled substances, and proportion of beneficiaries with cumulative controlled substance use greater than 30/90 days.

METHODS

Mississippi Medicaid prescription claims data for the years 2010-2012 were analyzed. The drugs dispensed were identified using National Drug Codes (NDCs). Mississippi Medicaid managed care enrollees were not included in the analysis. Only beneficiaries aged 15-64 were included in the analysis since controlled substances are not usually prescribed to children and data for beneficiaries aged 65 years or more are incomplete since Medicare is the primary payer for these individuals. In addition, beneficiaries had to be enrolled in Medicaid for at least one month in the respective calendar year. Individuals younger than 65 years and eligible for Medicare (dual eligibles) were also excluded from the study on account of incomplete data. Information about age of the beneficiaries and eligibility was identified from a recipient master file containing demographic and enrollment information for all Mississippi Medicaid enrollees. The recipient master file and the prescription claims file were linked using a unique beneficiary identification number.

RESULTS

The results for use of controlled substance pain medications among Mississippi Medicaid beneficiaries during 2010-2012 have been presented in Table 1. The number of prescriptions for controlled substance pain medications per beneficiary decreased from 2010 (1.29) to 2011 (0.94), but increased in 2012 (0.98). When the analysis for the year 2012 was restricted to beneficiaries who were expected to be in fee-for-service in 2013 in order to estimate the projected value for 2013, this number reduced to 0.57.

Table 1. Use of controlled substance pain medications in fee-for-service Mississippi Medicaid (MS-DUR analysis)

Controlled substance category	2010	2011	2012	2013*
Hydrocodone and relatives	195,253	162,227	168,349	35,956
Oxycodone and relatives	26,038	24,068	26,310	7,133
Meperidines	1,052	737	613	176
Methadone	1,118	772	753	89
Morphine and derivatives	6,538	4,463	4,680	1,043
Fentanyl and relatives	5,182	3,584	3,914	1,474
Controlled cough suppressants	14,366	10,908	11,857	4,567
Detoxifiers	183	138	191	33
Painkillers for headache/migraine	12	18	99	48
Tramadol	26,549	21,135	20,199	4,293
Propoxyphene	36,296	-	-	-
Miscellaneous	4,293	5,192	4,337	244
Total prescriptions	316,790	233,242	241,302	55,056
Average Monthly total	26,385	19,437	20,109	4,588
Average covered beneficiaries (15-64 years)	245,641	249,378	245,503	97,297
Number of prescriptions for controlled substances per beneficiary (15-64 years)	1.29	0.94	0.98	0.57

*Projected use of controlled substance pain medications in fee-for-service Mississippi Medicaid beneficiaries in the year 2013; calculated based on claims during 2012 and the likelihood of being enrolled in fee-for-service Mississippi Medicaid in 2013.

The findings from the SNCS report have been presented in Table 2. In general, our findings are lower than those obtained by SNCS. For example, the number of prescriptions for controlled substance pain medications per beneficiary obtained from our analysis was 1.29 as compared to 1.55 obtained by SNCS. The difference in findings may be attributed to different sources of data used in the studies and how the drugs were categorized. With the use of linked beneficiary demographic characteristic and pharmacy claims files, our estimates are likely to be more accurate than those of SNCS.

Table 2. Findings from the report entitled “Usage of controlled substance pain medications in Medicaid” from Special Needs Consulting Services (SNCS)

Controlled substance category	2010 (SNCS Report)	2010 (MS-DUR)
Hydrocodone and relatives	213,838	195,253
Oxycodone and relatives	28,725	26,038
Meperidines	2,679	1,052
Methadone	1,271	1,118
Morphine and derivatives	9,282	6,538
Fentanyl and relatives	7,596	5,182
Controlled cough suppressants	5,953	14,366
Detoxifiers	3,286	183
Painkillers for headache/migraine	13,261	12
Tramadol	33,594	26,549
Propoxyphene	-	36,296
Miscellaneous	5	4,293
Total prescriptions	319,490	316,790
Average Monthly total	26,624	26,385
Average covered beneficiaries (15-64 years)	206,526	245,641
Number of prescriptions for controlled substances per beneficiary (15-64 years)	1.55	1.29

Table 3 reports the performance of Mississippi Medicaid in terms of the three quality indicators. The number of prescriptions per beneficiary among beneficiaries who had a prescription for controlled substances decreased from 2010 (3.58) to 2011 (3.06), but increased in 2012 (3.18). When only the beneficiaries who were expected to be in fee-for-service in 2013 were included in the analysis for the year 2012 in order to estimate the projected value for 2013, this number reduced to 2.33. The proportion of beneficiaries who had a prescription for controlled substances decreased from 2010 (36.0%) to 2011 (31.0%), but remained nearly constant in 2012 (30.9%). The projected value for 2013 was found to be 24.3%. The proportion of beneficiaries with cumulative controlled substances use greater than 30 days decreased from 26.8% in 2010 to 22.6% in 2011 and thereafter increased to 23.9% in 2012. The projected value for 2013 was found to be 12.7%. Similar results were obtained for proportion of beneficiaries with cumulative controlled substances use greater than 90 days.

Table 3. Proposed Quality indicators for controlled substance pain medication use among Mississippi Medicaid beneficiaries

	2010	2011	2012	2013*
Average covered beneficiaries (15-64 years)	245,641	249,378	245,503	97,297
Number of beneficiaries with a controlled substance prescription	88,478	76,171	75,779	23,643
Proposed Measures				
1. Proportion of beneficiaries with a prescription for controlled substances (out of total eligible beneficiaries)	36.02%	30.54%	30.87%	24.30%
2. Number of controlled substance prescriptions per beneficiary among beneficiaries with a prescription for controlled substances	3.58	3.06	3.18	2.33
3a. Number (%) of beneficiaries with cumulative controlled substances use greater than 30 days	23,783 (26.88%)	17,206 (22.59%)	18,122 (23.91)	3,008 (12.72)
3b. Number (%) of beneficiaries with cumulative controlled substances use greater than 90 days	12,790 (14.46%)	9,007 (11.82%)	9,971 (13.16)	1,387 (5.87)

* Projected value for the year 2013; calculated based on claims during 2012 and the likelihood of being enrolled in fee-for-service Mississippi Medicaid in 2013.

Proposed Quality Measures

Potential quality **Measure 1**, i.e. the proportion of beneficiaries who had a prescription for controlled substance pain medications, provides information about the prevalence of controlled substance pain medication prescriptions in the Mississippi Medicaid population. In situations where use of controlled substances is deemed as appropriate, guidelines from state medical boards recommend that physicians conduct periodic review of the health state of the patients on controlled substances to make decisions about continued use of these medications.

Measure 2 provides a beneficiary-level average number of controlled substance prescriptions per beneficiary among those with a prescription for controlled substances. This metric provides a more precise estimate of controlled substance utilization among the Medicaid population compared to the more global number reported in the SNCS report, which averaged all controlled substance use over ALL beneficiaries.

Guidelines also recommend that physicians consider other treatment modalities prior to deciding about continued use of controlled substances. Measures such as number of prescriptions per beneficiary among beneficiaries who had a prescription for controlled substances and proportion of beneficiaries with cumulative controlled substance use greater

than 30/90 days could be useful in understanding the extent of continued use of controlled substance pain medications in the Mississippi Medicaid population. **Measure 3a** provides an estimate of the proportion of beneficiaries with cumulative controlled substance use that exceeds 30 days. **Measure 3b** provides a similar estimate, with a more liberal cumulative treatment of 90 days.

CONCLUSIONS

The SNCS report created metrics of controlled substance use in the Medicaid population using State Drug Utilization Data and Medicaid Statistics Information System (MSIS) data, which are aggregated, non-linked data from CMS. Because the data used by SNCS cannot be linked at the beneficiary level, only crude estimates of utilization may be estimated. Several potential quality measures have been proposed by MS-DUR that overcome the limitations of the SNCS measures and provide a more comprehensive representation of controlled substance utilization in the fee-for-service Medicaid population.

DUR BOARD ACTION REQUESTED

MS-DUR is seeking discussion and input from the DUR Board on these proposed measures as well as a formal recommendation from the DUR Board to monitor these measures through retrospective DUR. No prescriber or pharmacy intervention is being proposed at this time related to these measures, as there are other measures currently monitored related to controlled substances utilization that are more conducive to provider intervention and education.

“GRANDFATHERING” CRITERIA WHEN PREFERRED MEDICATIONS CHANGE TO NON-PREFERRED ON THE PREFERRED DRUG LIST

BACKGROUND

The Mississippi Division of Medicaid (DOM) Pharmacy and Therapeutics (P&T) Committee meets quarterly to review new drugs and selected therapeutic classes. One of the responsibilities of the P&T Committee is to make recommendations to DOM regarding the preferred drug status of products based on clinical benefits and the net cost to DOM after Federal and state rebates are considered. Major changes are made to the DOM Preferred Drug List (PDL) each January with minor changes made each quarter. It is not uncommon that existing drugs may shift from preferred to non-preferred status during a quarterly or annual change to the PDL. When this happens, the P&T Committee makes recommendations regarding the clinical need to “grandfather” beneficiaries who are on continuous stable therapy with an agent that is moving to non-preferred status.

Grandfathering is frequently done in order to allow providers and beneficiaries to continue a current therapy without the necessity of manually obtaining prior authorization after the drug becomes non-preferred. The major criterion that is examined in the electronic PA process (SmartPA) is whether the patient is on “continuous stable therapy.” Continuous therapy is typically defined as having XX days of supply of the medication during the last YY days prior to the currently submitted claim for the medication. For example, if we wanted to define continuous therapy as being compliant (taking medication 80% of the time) for at least 90 days of therapy, the criteria would be that at least 90 days supply of therapy was dispensed in last 112 calendar days (90 days of therapy / 112 calendar days = 80.4% compliant).

Defining the “stable” portion of the grandfathering criteria is not as simple as defining the continuous therapy component. Stable therapy can be defined in a variety of ways with different levels of specificity. Several operation definitions for continuous therapy are described in Table 1 below.

Table 1: Potential Definitions of Continuous Therapy	
Operational definition	What constitutes a change in therapy
<i>Same drug</i> taken continuously	Only a change in the drug being taken is considered to be a change in therapy. No concern for brand/generic status or strength of drug.
<i>Same drug and strength</i> taken continuously	Any change in the strength or the drug being taken would be considered a change in therapy. No concern for brand/generic status.
<i>Same drug, strength and dosing</i> taken continuously	Any change in the frequency of dosing, strength or the drug being taken would be considered a change in therapy. No concern for brand/generic status.

As a general rule, if we want to encourage use of preferred drugs, a more rigid definition of continuous therapy should be used. However, sometimes clinical situations can exist where it

would be better to use a more lenient definition of continuous therapy; thus allowing beneficiaries to remain on the same medication longer. A good example of this would be with mental health medications.

DOM wants to get input from the DUR Board as to the way in which continuous therapy should be defined for different therapeutic areas. Selected therapeutic classes currently reviewed for the PDL include the following.

Selected PDL Therapeutic Classes for Discussion		
Class		Examples of Currently Preferred Agents
Alzheimer's Agents		Aricept, Exelon
Androgenic Agents		Testim
Angiotensin Modulators		
	ACE Inhibitors	catopril, lisinopril
	ARBs	Avapro, Diovan, Micardis
Anticoagulants		Coumadin, Lovenox, Pradaxa
Anticonvulsants		carbamazepine, Dilantin, ethosuzimide
Antidepressants		bupropion, Effexor XR, citalopram, Lexapro
Antimigraine Agents, Triptans		Maxalt, Treximet, Zomig
Antiparkinson's Agents		benztropine, ropinirole
Antipsychotics, Oral		Abilify, clozapine, risperidone, Seroquel
Beta Blockers		atenolol, Bystolic, nadolol
BPH Agents		doxazosin, Flomax, Uroxatral
Bronchodilators & COPD Agents		Atrovert HFA, Spiriva
Bronchodilators, Beta Agonists		Proventil HFA, Foradil
Hypoglycemic		
	Incretin Mimetics/Enhancers	Gyetta, Januvia, Tradjenta
	Meglitinides	Prandon
	TZDs	pioglitazone
Intranasal Rhinitis Agents		ipratropium, Flonase, Nasonex
Leukotriene Modifiers		Accolate, Singulair
Lipotropics, Statins		Crestor, Lipitor, pravastatin
Proton Pump Inhibitors		Aciphex, Nexium
Sedative Hypnotics		estazolam, triazolam, Lunesta, zolpidem
Stimulants and Related Agents		dexamethylphenidate IR, Methylin, Daytrana, Vyvanse

DUR BOARD ACTION REQUESTED

Recommendations regarding how rigidly continuous therapy should be defined when grandfathering current therapies for the therapeutic categories discussed.

DRUG UTILIZATION AND COSTS ASSOCIATED WITH CORONARY ARTERY DISEASE IN MISSISSIPPI MEDICAID FEE-FOR-SERVICE DATA IN THE YEAR 2012

OBJECTIVES

The objectives for this analysis were to estimate utilization of drugs by Coronary Artery Disease (CAD) beneficiaries and to calculate the costs incurred by Medicaid for each Coronary Artery Disease (CAD) beneficiary per month in the year 2012.

METHODS

Mississippi Medicaid fee-for-service data from January 1st 2012 to December 31st 2012 was used. Per-member-per-month costs were calculated using the same methodology used by the Center for Medicare and Medicaid Services (CMS).¹ Cost for each person was obtained by averaging the total expenses of a given beneficiary across the number of months he is eligible for in the year 2012. Final per member per month costs were obtained by averaging across all beneficiaries with at least one identifiable ICD9 diagnosis code for Coronary Artery Disease (CAD). Drug utilization was checked using NDC codes obtained from the pharmacy claims files.

RESULTS

A total of 5,470 CAD beneficiaries were identified in the year 2012 using ICD9 codes. A total of 886 of these beneficiaries did not have any associated pharmaceutical expenses. Together, the CAD beneficiary population accounted for nearly \$10.89 million in expenses related to drugs alone. The average per-member-per-month prescription cost incurred by the state in 2012 was estimated to be \$175.62 in the fee-for-service population with CAD. The top five drugs (not necessarily specific to CAD) which accounted for the highest expenditure include Plavix, Lantus, Lipitor, Omeprazole and Letairis. Plavix, Lantus and Lipitor alone accounted for 16.2% of total annual expenditure.

TABLE 1 Drug utilization data for the year 2012 in beneficiaries with coronary artery disease

Drug	# of fills in the year 2012	# of units dispensed in 2012	Total cost (\$)
Plavix	5,842	178,214	1,210,966.98
Lantus	1,135	23,225	297,002.31
Lipitor	1,551	47,063	258,889.76
Omeprazole	3,368	118,667	232,696.63
Letairis	25	750	158,916.36

¹ Medicaid Pharmacy Benefit Use and Reimbursement - Introduction and Chartbooks. Available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MedicaidPharmacy.html>. Accessed on: 4/8/2012.

USE OF LIPID LOWERING THERAPY IN BENEFICIARIES WITH CORONARY ARTERY DISEASE

BACKGROUND

The National Quality Forum (NQF) published a measure for the effective management of coronary artery disease (CAD). This measure assesses use of lipid lowering therapy (LLT) in beneficiaries with CAD. The denominator of this measure is the number of beneficiaries with CAD aged 18 years or more, while the numerator of the measure assesses the number of beneficiaries on LLT for each year of data.

METHODOLOGY

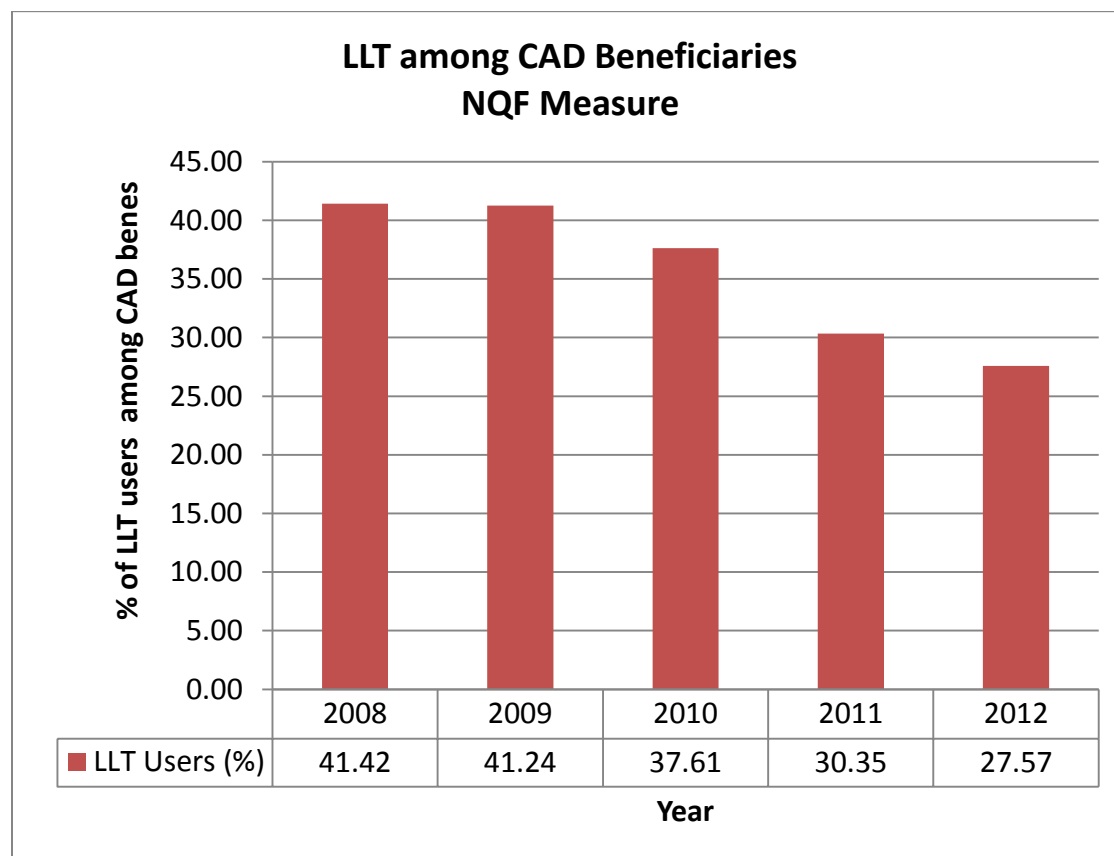
Administrative claims for calendar years 2008 to 2012 were used to assess the measure in the Mississippi Medicaid population. CAD beneficiaries were identified using International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes for CAD (Appendix 1). Beneficiaries receiving any lipid lowering drug, regardless of the number of fills, were identified using drug IDs in appendix 1.

RESULTS

Table 1 provides the percentage of beneficiaries on LLT among CAD beneficiaries by year. Figure 1 shows the trend in LLT users among CAD beneficiaries over the period of four years. Percentage use of lipid lowering drugs is seen to be decreasing from 2008-2012 with the highest percentage of in 2008.

Table 1. Percentage of LLT users among CAD beneficiaries					
Year	2008	2009	2010	2011	2012
CAD	6,920	7,316	7,521	5,625	5,469
LLT users (%)	2,866 (41.4%)	3,017 (41.2%)	2,829 (37.6%)	1,707 (30.4%)	1,508 (27.6%)

*CAD = Coronary Artery Disease; LLT = Lipid Lowering Therapy

Figure 1: Percentage of LLT Users among CAD Beneficiaries

*CAD = Coronary Artery Disease; NQF: National Quality Forum; LLT = Lipid Lowering Therapy

Table 2 provides the demographic characteristics of LLT users and non-users in the CAD population.

Table 2. Percentage of LLT users among CAD beneficiaries by year										
	2008 (N=6,920)		2009 (N=7,316)		2010 (N=7,521)		2011 (5,625)		2012 (5,469)	
	LLT use		LLT use		LLT use		LLT use		LLT use	
	Yes N (%)	No N (%)	Yes N (%)	No N (%)	Yes N (%)	No N (%)	Yes N (%)	No N (%)	Yes N (%)	No N (%)
Age category										
≥18 to	3	40	6	68	2	57	2	49	2	50
≤25 years	(0.10)	(0.99)	(0.20)	(1.58)	(0.07)	(1.21)	(0.12)	(1.25)	(0.13)	(1.26)
>25 to ≤35	42	182	46	187	45	211	38	178	31	193
years	(1.47)	(4.49)	(1.52)	(4.35)	(1.59)	(4.50)	(2.23)	(4.54)	(2.06)	(4.87)
>35 to	295	478	323	497	271	492	157	417	152	381
≤45 years	(10.29)	(11.79)	(10.71)	(11.56)	(9.58)	(10.49)	(9.20)	(10.64)	(10.08)	(9.62)
>45 to	949	1,159	1,027	1,262	961	1,442	589	1,067	510	1,063
≤55 years	(33.11)	(28.59)	(34.04)	(29.36)	(33.97)	(30.73)	(34.50)	(27.23)	(33.82)	(26.84)
>55 years	1,577	2,195	1,615	2,285	1,550	2,490	921	2,207	813	2,274
	(55.02)	(54.14)	(53.53)	(53.15)	(54.79)	(53.07)	(53.95)	(56.33)	(53.91)	(57.41)
Gender										
Male	1,162	1,570	1,241	1,744	1,238	1,927	784	1,636	673	1,603
	(40.54)	(38.73)	(41.13)	(40.57)	(43.76)	(41.07)	(45.93)	(41.76)	(44.63)	(40.47)
Female	1,704	2,484	1,776	2,555	1,591	2,765	923	2,282	835	2,358
	(59.46)	(61.27)	(58.87)	(59.43)	(56.24)	(58.93)	(54.07)	(58.24)	(55.37)	(59.53)
Race										
Caucasian	1,227	1,851	1,288	1,960	1,235	2,188	814	2,008	720	1,917
	(42.81)	(45.66)	(42.69)	(45.59)	(43.66)	(46.63)	(47.69)	(51.25)	(47.75)	(48.40)
Hispanic	5	9	9	8	5	12	5	14	7	15
	(0.17)	(0.22)	(0.30)	(0.19)	(0.18)	(0.26)	(0.29)	(0.36)	(0.46)	(0.38)
Native	2	6	2	10	4	13	0	7	1	20
American	(0.07)	(0.15)	(0.07)	(0.23)	(0.14)	(0.28)		(0.18)	(0.07)	(0.5)
Asian	4	12	7	9	10	10	2	9	1	2
	(0.14)	(0.30)	(0.23)	(0.21)	(0.21)	(0.21)	(0.12)	(0.23)	(0.07)	(0.05)
African	1,366	1,909	1,428	2,004	1,313	2,124	749	1,616	644	1,741
American	(47.66)	(47.09)	(47.33)	(46.62)	(46.41)	(45.27)	(43.88)	(41.25)	(42.71)	(43.95)
Other/	262	267	283	308	262	345	137	264	135	266
Unknown	(9.14)	(6.59)	(47.97)	(7.14)	(9.26)	(7.35)	(8.03)	(6.74)	(8.95)	(6.72)
*CAD=Coronary artery disease; LLT = Lipid Lowering Therapy										

Table 3 provides the frequency of plan IDs among LLT users. A vast majority of beneficiaries had plan ID 100 which denotes that they are regular adults. Few beneficiaries had plan ID 200 which indicates that they were long term care residents.

Table 3. Frequency of plan IDs among LLT users					
Year	2008	2009	2010	2011	2012
LLT users	2,866	3,017	2,829	1,707	1,508
PLAN ID	N (%)	N (%)	N (%)	N (%)	N (%)
100	2,784 (97.14)	2,913 (96.55)	2,721 (96.18)	1,598 (93.61)	1,417 (93.97)
200	81 (2.83)	102 (3.38)	108 (3.82)	109 (6.39)	91 (6.03)
400	0	2 (0.07)	0	0	0
700	1 (0.04)		0	0	0

*LLT = Lipid Lowering Therapy

Plan IDs: 100 = regular adults; 200 = Long-Term Care; 400 = EPSDT (children); 700 = 'K-baby'

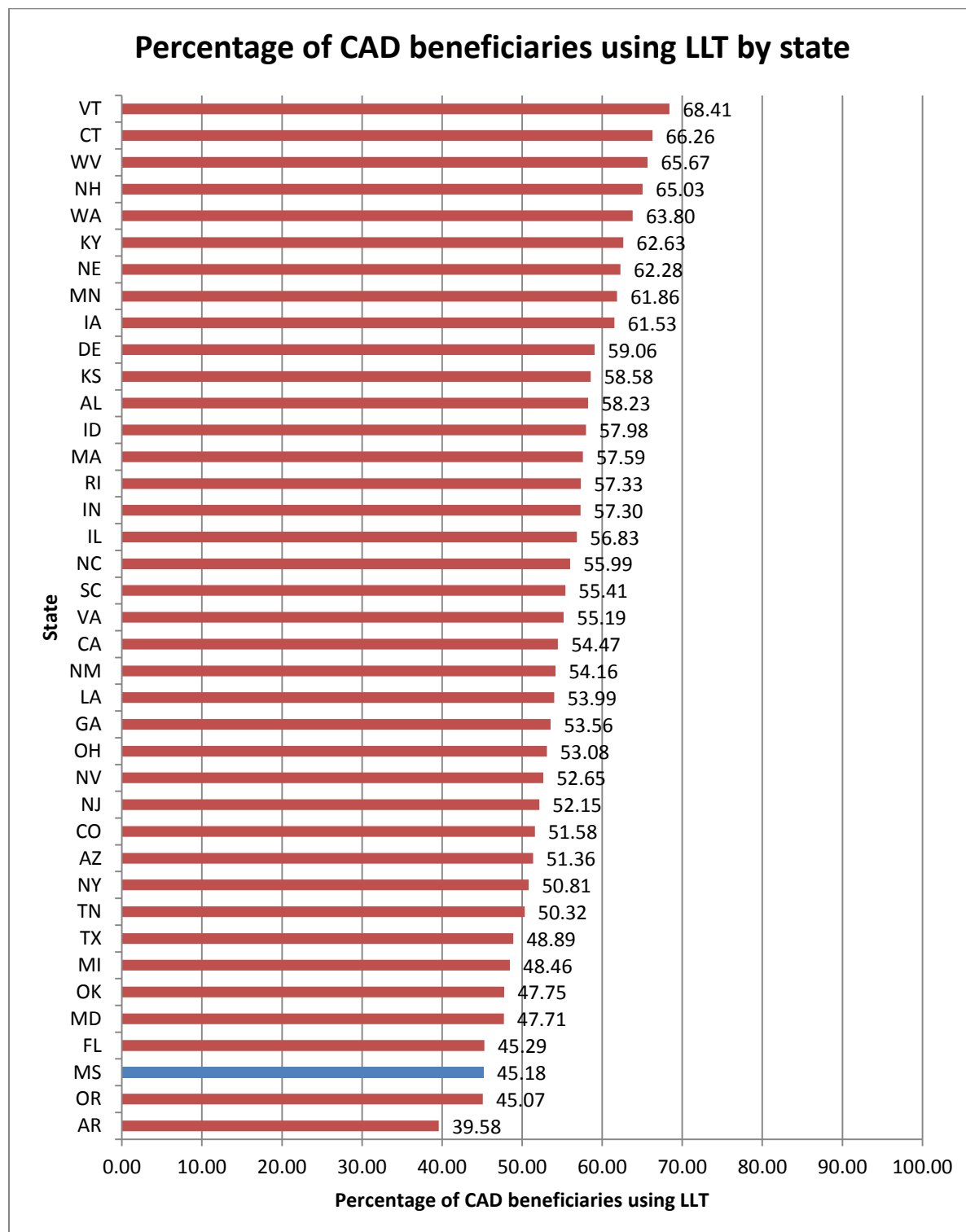
Table 4 provides the frequency of primary diagnoses recorded each year at the prescription-level for CAD beneficiaries. Year 2010 had the maximum number of CAD claims. In all the years, ICD-9-CM code of 414 (other forms of chronic ischemic heart disease) was the most prevalent as the primary diagnosis code in CAD claims.

Table 4. Frequency of primary diagnoses in medical claims for CAD					
Year	2008	2009	2010	2011	2012
Total Rxs	85,408	99,449	104,900	75,266	77,406
ICD-9-CM codes	N (%)	N (%)	N (%)	N (%)	N (%)
410	3,900 (4.57%)	4,566 (4.59%)	4,014 (3.83%)	2,641 (3.51%)	2,741 (3.54%)
411	4,458 (5.22%)	5,451 (5.48%)	6,709 (6.4%)	3,040 (4.04%)	2,750 (3.55%)
412	1,194 (1.4%)	1,649 (1.66%)	1,371 (1.31%)	1,006 (1.34%)	890 (1.15%)
413	6,043 (7.08%)	6,166 (6.2%)	7,233 (6.9%)	4,008 (5.33%)	4,025 (5.2%)
414	30,114 (35.26%)	32,879 (33.06%)	33,093 (31.55%)	24,239 (32.2%)	24,779 (32.01%)
V45.81	867 (1.02%)	938 (0.94%)	943 (0.9%)	691 (0.92%)	470 (0.61%)
V45.82	397 (0.46%)	553 (0.56%)	676 (0.64%)	417 (0.55%)	589 (0.76%)
CAD as a Secondary Diagnosis	38,435 (45%)	47,247 (47.51%)	50,861 (48.49%)	39,224 (52.11%)	41,162 (53.18%)

*CAD = Coronary Artery Disease

410 = acute myocardial infarction; 411 = other acute and sub-acute forms of ischemic heart disease; 412 = old myocardial infarction; 413 = angina pectoris; 414 = other forms of chronic ischemic heart disease

Figure 2 provides a graphical representation of the percentage of LLT users by state in the national Medicaid data. Mississippi (45.18%) ranked the third lowest nationally before Oregon (45.07%) and Arkansas (39.58%). Vermont had the highest percentage of LLT users among CAD beneficiaries (68.41%).



EDUCATIONAL OUTREACH

MS-DUR has prepared an educational letter about this initiative (see Appendix) that will be used in targeted provider outreach. This letter will include beneficiary-level information as well as the objectives of the initiative, how the beneficiaries were identified, cursory supporting evidence for the initiative, and any action required of the prescriber.

DUR BOARD ACTION REQUESTED

The Division of Medicaid and MS-DUR would like input and discussion from the DUR Board on how to make this educational initiative most effective and whether any other actions should be considered in order to improve our performance on the CAD LLT quality indicator.

CAD REPORT APPENDIX**1. ICD-9-CM codes used to identify CAD beneficiaries**

ICD-9 codes	Condition
410	Acute myocardial infarction
411	Other acute and sub-acute forms of ischemic heart disease
412	Old myocardial infarction
413	Angina pectoris
414	Other forms of chronic ischemic heart disease
V45.81	Aorto-coronary bypass status
V45.82	Percutaneous transluminal coronary angioplasty status

2. Drugs IDs used to identify lipid lowering therapies*

Class	Drug Name	Example Products	Multum Drug ID
HMG-CoA Reductase Inhibitors	atorvastatin	Lipitor	d04105
	fluvastatin	Lescol	d03183
	lovastatin	Mevacor	d00280
	pravastatin	Pravachol	d00348
	rosuvastatin	Crestor	d04851
	simvastatin	Zocor	d00746
Combination Products	amlodipine/atorvastatin	Caduet	d05048
	niacin/lovastatin	Advicor	d04787
	niacin/simvastatin	Simcor	d07110
	ezetimibe/simvastatin	Vytorin	d05348
	pravastatin/aspirin	Pravigard PAC	d04883
2-azetidinone	ezetemibe	Zetia	d04824
Bile Acid Sequestrants	cholestyramine	Questran	d00193
	colesevelam	Welchol	d04695
	colestipol	Cholestid	d00744
Fibric Acid Derivatives	Fenofibric acid	Trilipix	d07371
	fenofibrate	Lofibra	d04286

*products containing these drug molecules

UTILIZATION OF SMOKING CESSATION PRODUCTS IN THE MISSISSIPPI MEDICAID FEE-FOR-SERVICE POPULATION

BACKGROUND

State Medicaid programs nationwide offer a variety of types and combinations of smoking cessation aides. It has been shown that the Medicaid population has a 50% higher prevalence of tobacco use than the general population.² In the US population, a total of 23% smoke with 36% of the Medicaid population being classified a smoker.³ Pregnant women enrolled in the Medicaid program are twice as likely to smoke as pregnant women in the general population.² In 2011, 26% of the Mississippi population was classified as smokers, with only 20.1% of the population nationally smoking.⁴ During that same year 61.2% of the Mississippi smokers attempted to quit, which is more than the 59.6% of national smokers who made an attempt to quit smoking.⁴

Smoking is a chronic disease that accounts for more than 435,000 deaths each year and causing multiple types of cancers, heart disease, stroke, chronic obstructive pulmonary disease (COPD), and many other diseases.⁵ With the cause of so many diseases, the financial burden each year is estimated at \$96 billion for direct medical expenses and \$97 billion in lost productivity.⁵ According to the guidelines, if all current Medicaid smokers quit, after 5 years, the annual savings to Medicaid would be \$9.7 billion.⁵

Studies have suggested that more than 70% of smokers want to quit, but only 44% report an actual quit attempt.⁵ Most of these attempts are done without smoking cessation aides and are unsuccessful.⁵ Currently, there are seven FDA approved smoking cessation medications available (see Table 1). There is no dosing algorithm available, but dosing recommendations usually depend on the number of cigarettes smoked per day.⁵ All therapy listed are first line recommendations.⁵

The Mississippi Division of Medicaid (DOM) is seeking recommendations from the DUR Board on ways to enhance and promote smoking cessation efforts in the Medicaid population.

² Li C, Dresler CM. Medicaid Coverage and Utilization of Covered Tobacco-Cessation Treatments: The Arkansas Experience. *Am J Prev Med.* 2012 June [cited 2013 April]. <http://www.ncbi.nlm.nih.gov/pubmed/22608374>

³ McMenamin SB, Halpin HA, Bellows NM. Knowledge of Medicaid Coverage and Effectiveness of Smoking Treatments. *Am J Prev Med.* 2006 Nov [cited 2013 April]. <http://www.ncbi.nlm.nih.gov/pubmed/17046407>

⁴ Mississippi: Smoking. Kaiser Family Foundation [cited 2013 April]. <http://www.statehealthfacts.org/profileind.jsp?cat=2&sub=24&rgn=26>

⁵ Fiore MC, Jaen CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. US Dept of Health and Human Services. 2008 May [cited 2013 April]. <http://bphc.hrsa.gov/buckets/treatingtobacco.pdf>

Table 1 - Smoking Cessation Products Included in this Report

Nicotine Replacement Products	Rx/OTC availability
Nicotine Gum	OTC
Nicotine Lozenge	OTC
Nicotine Patch	OTC
Nicotine Inhaler	Rx
Nicotine Nasal Spray	Rx
Non-Nicotine Replacement Products	Rx/OTC availability
Bupropion SR	Rx
Varenicline	Rx

Current MS Medicaid Coverage of Smoking Cessation Products

The Mississippi Division of Medicaid currently covers the drug products listed in Table 1 for all beneficiaries pursuant a valid prescription, as well as group and individual counseling, which is limited to pregnant beneficiaries. Prescriptions for smoking cessation products count against the monthly prescription benefit limit, where applicable and are the standard copayments apply.

Survey of Other Medicaid Programs

Arkansas Medicaid: Covers 4 FDA-approved tobacco-cessation pharmacotherapies (bupropion SR, nicotine patch, nicotine gum, and varenicline) and individual counseling services by authorized providers.⁶ *These products are excluded from a copayment and do not count toward the monthly prescription limit.* The use of bupropion SR with nicotine gum or patch is allowed each month. The counseling services available do not count against the annual limit of 12 visits. The products covered require a prescription and prior authorization.⁶

New York Medicaid: FFS Medicaid covers all first-line, FDA-approved medications except nicotine lozenges. Managed care plans cover at least the nicotine patch, and nicotine gum, as well as bupropion SR and varenicline. Coverage is for 2 three month periods each year and does cover combinations. Inpatient counseling is covered, but not outpatient. Pediatrics is not covered for reimbursement. Documentation is needed for counseling reimbursement to physicians.⁷

Kentucky: this plan requires a referral from a Medicaid physician, nurse practitioner, or physician assistant to get the benefits. A prescription is also needed, even for OTC products.

⁶ Li C, Dresler CM. Medicaid Coverage and Utilization of Covered Tobacco-Cessation Treatments: The Arkansas Experience. Am J Prev Med. 2012 June [cited 2013 April]. <http://www.ncbi.nlm.nih.gov/pubmed/22608374>

⁷ Medicaid Smoking Cessation Benefit Reimbursement Frequently Asked Questions. [cited 2013 April]. <http://www.nyc.gov/html/doh/downloads/pdf/smoke/smoke-medicare-reimbursement-faq.pdf>

There is no copayment for the products and all FDA-approved medications are covered for two 90 day periods per year. For non-preferred products, a prior authorization is required. Refills require approval through the Department for Medicaid Services, Division of Medical Management. To begin the process, an assessment taking a minimum of 10 minutes is required, and has to be face-to-face. The interaction must include the A's of tobacco cessation (ask, advice, assess).⁸

Massachusetts: All medications, as well as group counseling, individual counseling and a “quit line” are covered. Co-payments are required and are \$1 for generics and \$3 for brand name medications. A prior authorization is required for the nicotine inhaler and nasal spray. A PA is also required if the patient wants to extend the duration of treatment past 90 days (24 weeks for varenicline). If the number of quit attempts is greater than 2 per year, a PA is also required.⁹ *A study published has shown that for every \$1 Medicaid spends on the quit smoking program, they have saved more than \$3.*¹⁰ These savings were seen a little more than 1 year after the benefits were started.¹⁰

METHODS

Mississippi Medicaid fee-for-service prescription claims data for the years 2012-2013 were analyzed. Only beneficiaries who were continuously enrolled in Medicaid were considered in the analysis. Individuals eligible for Medicare and Medicaid (dual eligibles) were also excluded from the study due to lack of access to Medicare Part D data. Information about the beneficiary demographics and eligibility was identified from a recipient master file containing demographic and enrolment information for all Mississippi Medicaid enrollees.

Utilization of smoking cessation products, including nicotine replacement therapies, bupropion hydrochloride, and varenicline was studied. All results were reported by age, gender, race, pregnancy status, and Medicaid plan ID. Since bupropion is also used for treating clinical depression, separate analyses were conducted for beneficiaries with diagnosis codes for depression. In addition, patterns in the use of the smoking cessation products in terms of number and percentage of single and multiple medication users were reported. Distribution of beneficiaries in terms of number of fills for varenicline was determined in order to assess new therapy starts and duration of therapy. For this purpose, a therapy-level analysis was conducted wherein use of a new varenicline starter pack (which may or may not have been followed by a continuation pack) by the same beneficiary was considered separately in the analysis.

⁸ Medicaid Tobacco Cessation Program. 2013 January. [cited 2013 April]. <http://chfs.ky.gov/dms/TobaccoCessation.htm>

⁹ Massachusetts. American Lung Association. 2010. [cited 2013 April].
<http://lungusa2.org/cessation2/statedetail.php?stateId=25>

¹⁰ Meyers ML. New Study: Massachusetts Program to Help Medicaid Smokers Quit Saves \$3 for every \$1 Spent. Campaign for Tobacco-Free Kids. 2012 January. [cited 2013 April].
http://www.tobaccofreekids.org/press_releases/post/new_study_massachusetts_program

Distribution of beneficiaries in terms of number of therapies of varenicline during the study period was also reported. Finally, the impact of inclusion of smoking cessation products in the determination of prescription cap on the number of beneficiaries exceeding the prescription cap was reported.

The drugs dispensed were identified using National Drug Codes (NDCs). The presence of depression among the beneficiaries was identified by using an International Classification of Diseases code (ICD-9 CM code) of 311. Pregnant beneficiaries were identified using ICD-9CM code of V22.2 and it was assessed whether therapy was initiated within six months of pregnancy.

RESULTS

TABLE 1 Characteristics of beneficiaries using nicotine replacement products in the Mississippi Medicaid fee-for-service program^{1,2}			
Dosage form³	Inhaler (N=2)	Patch (N=20)	Gum (N=2)
RX/OTC status	RX	OTC	OTC
Age, N(%)			
14-30	0(0)	5(25)	1(20)
31-50	0(0)	3(15)	0(0)
51-64	2(100)	12(60)	3(60)
Gender, N(%)			
Male	0(0)	6(30)	1(20)
Female	2(100)	14(70)	4(80)
Race, N(%)			
Caucasian	0(0)	15(75)	3(60)
Hispanic	0(0)	0(0)	0(0)
American Indian	0(0)	0(0)	0(0)
African American	1(50)	5 (25)	1(20)
Unknown	1(50)	0(0)	1(20)
Pregnancy, N(%)			
Yes	0(0)	0(0)	0(0)
No	2(100)	20(100)	5(100)
Plan ID, N(%)			
100	2(100)	7(3.5)	1(50)
200	0(0)	6(30)	0(0)
400	0(0)	3(15)	1(50)
900	0(0)	4(20)	0(0)

¹Results are represented in terms of number and percentage of beneficiaries on the drug

²Observation period considered was January 2012-April 2013

³Some of the other dosage forms in which nicotine smoking cessation therapy is available include lozenges, powder, and spray. No claims for these products were observed in the data and hence they have not been mentioned in the table.

Table 2 includes beneficiaries who received a prescription for bupropion during the analysis period, with demographic characteristics stratified by the presence of a diagnosis of depression in the medical claims data. Because there are no ICD-9 diagnosis codes used to identify smoking status, the use of bupropion in this population must be inferred by ruling out other diagnoses. Based on the utilization of other smoking cessation therapies, it is likely that the utilization of bupropion is largely attributed to the treatment of depression, even in the absence of a relevant diagnosis code.

TABLE 2 Characteristics of beneficiaries on bupropion hydrochloride in the Mississippi Medicaid fee-for-service program^{1,2}			
	All patients (N=371)	Without depression diagnosis (N = 118)	With depression diagnosis (N = 253)
Age, N(%)			
<10	14(3.8)	6(5.1)	8(3.2)
11-30	227(61.2)	80(67.8)	147(58.5)
31-50	44(11.9)	9(7.0)	35(13.8)
51-64	85(23.0)	22(18.6)	63(24.9)
Gender, N(%)			
Male	127(34.2)	45(38.1)	82(32.4)
Female	244(65.8)	73(61.9)	171(67.6)
Race, N(%)			
Caucasian	202(54.5)	64(54.2)	132(54.6)
Hispanic	2(0.5)	0(0)	2(0.8)
American Indian	4(1.1)	3(2.5)	1(0.4)
African American	145(39.1)	42(32.6)	103(40.7)
Unknown	18(4.9)	9(7.6)	9(3.6)
Pregnancy, N(%)			
Yes	4(1.1)	2(1.7)	2(0.8)
No	367(98.9)	116(98.8)	251(99.2)
Plan ID, N(%)			
100	119(32.1)	38(32.2)	81(32.0)
200	53(15.4)	11(9.3)	46(18.2)
400	195(52.6)	69(58.5)	126(49.8)

¹Results are represented in terms of number and percentage of beneficiaries on the drug

²Observation period considered was January 2012-April 2013

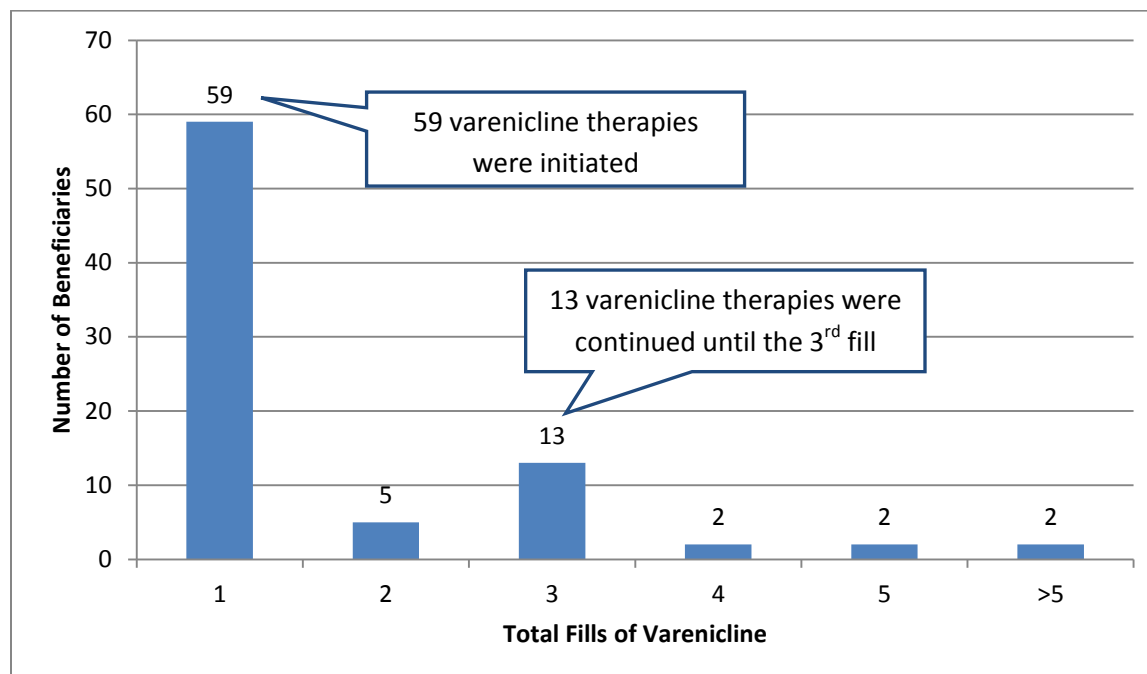
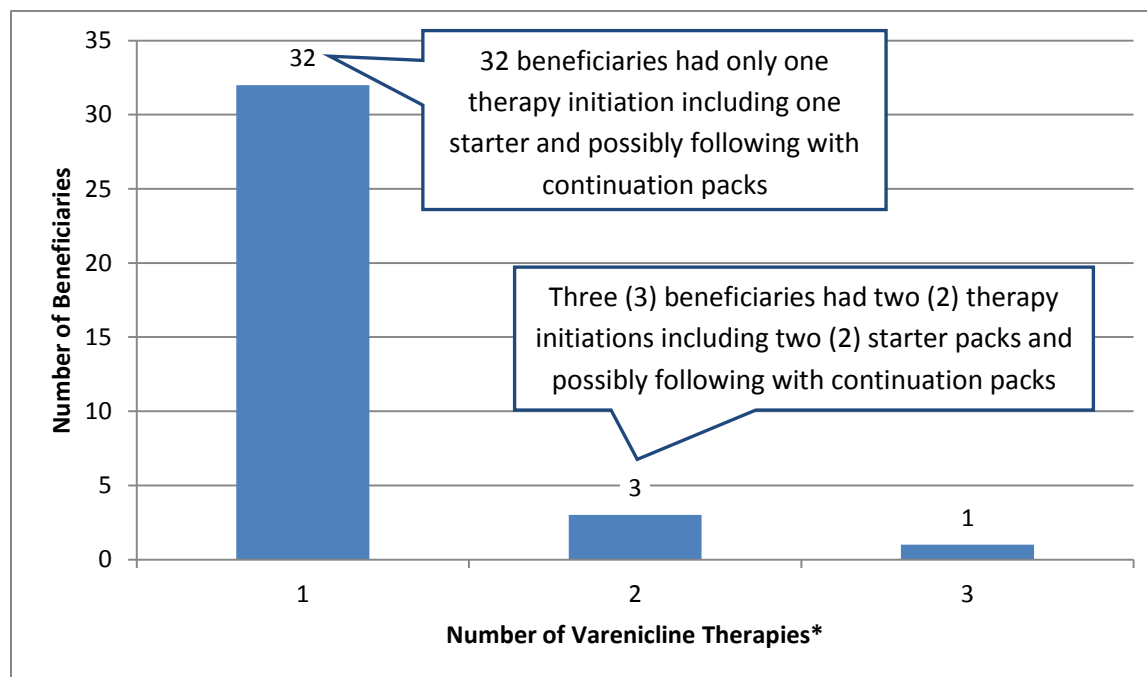
TABLE 3 Characteristics of beneficiaries on varenicline in the Mississippi Medicaid fee-for-service program^{1,2}		
Drug type	Starter (N=28)	Continuation (N=19)
Age, N(%)		
11-30	7(25)	5(26.3)
31-50	5(17.9)	4(21.1)
51-64	16(57.1)	10(52.6)
Gender, N(%)		
Male	8(28.6)	9(47.4)
Female	20(71.4)	10(52.6)
Race, N(%)		
Caucasian	22(78.6)	15(79.0)
Hispanic	0(0)	0(0)
American Indian	0(0)	1(5.3)
African American	5(17.9)	3(15.8)
Unknown	1(3.6)	0(0)
Pregnancy, N(%)		
Yes	0(0)	0(0)
No	28(100)	19(100)
Plan ID, N(%)		
100	25(89.3)	15(79.0)
200	2(7.1)	3(15.8)
400	1(3.6)	1(5.3)

¹Results are represented in terms of number and percentage of beneficiaries on the drug

²Observation period considered was January 2012-April 2013

TABLE 4 Patterns in the utilization of smoking cessation products in the Mississippi Medicaid fee-for-service program	
Therapy	Number (%) of beneficiaries
Nicotine only	18 (5.6)
Bupropion only	366 (86.3)
Varenicline only	33(7.8)
Bupropion followed by nicotine	3(0.7)
Nicotine followed by bupropion	1(0.2)
Varenicline followed by bupropion	1(0.2)
Nicotine followed by varenicline	2(0.4)

Note: the high utilization of bupropion relative to other smoking cessation therapies is likely due to the treatment of depression, despite the lack of relevant diagnoses found in the medical claims.

Figure 1: Utilization of varenicline in the Mississippi Medicaid fee-for-service program***Figure 2: Distribution of number of varenicline therapies per beneficiary in the Mississippi Medicaid fee-for-service program***

*For this analysis, a therapy was defined as a claim for a starter pack which may or may not have been followed by a continuation pack.

TABLE 5 Impact of inclusion of smoking cessation drugs on the beneficiary's prescription cap							
Month for the year 2013	Total number (%) of benes on smoking cessation drugs per month	n (%) of benes on smoking cessation drugs subject to the Rx benefit limit	Number of beneficiaries (%) who would exceed the prescription benefit limit with _____ smoking cessation claims:				n (%) of benes not exceeding the prescription benefit limit with >3 smoking cessation claims
			0 (at Rx limit)	1	2	3	
January	433	359 (100)	46 (12.8)	106 (29.5)	64(17.8)	65 (18.1)	78 (21.7)
February	429	352 (100)	42 (11.9)	92 (26.1)	64 (18.2)	77 (21.9)	77 (21.9)

Example: 64 beneficiaries would exceed the prescription benefit limit if 2 smoking cessation prescriptions were processed.

CONCLUSIONS

Other state Medicaid programs have benefit designs that remove limitations to smoking cessation, such as removing copayments for smoking cessation products and/or allowing for smoking cessation therapies not to count against a prescription benefit limit. Utilization data has been presented for various scenarios to provide support for discussion.

DUR BOARD ACTION REQUESTED

The Division of Medicaid is seeking discussion and input from DUR Board on ways to encourage smoking cessation in the Mississippi Medicaid population. Particular topics of discussion that Medicaid is seeking input on include:

- How to encourage smoking cessation efforts in general and in specific populations (e.g., pregnancy)
- Benefit changes to remove limitations from smoking cessation efforts, including:
 - removing or reducing copays on smoking cessation products
 - making smoking cessation prescriptions not count against monthly prescription benefit limits

Exceptions Monitoring Criteria Recommendations

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

Criteria Recommendations**1. Complera (emtricitabine/rilpivirine/tenofovir disoproxil fumarate) contraindicated with proton pump inhibitors**

Message: In January 2013, the FDA updated the labeling of Complera (emtricitabine/rilpivirine/tenofovir disoproxil fumarate) containing products to include a contraindication in patients taking proton pump inhibitors such as dexlansoprazole, esomeprazole, lansoprazole, omeprazole, pantoprazole, and rabeprazole because it may result in loss of virologic response and possible resistance and cross-resistance.

Exception Type: DDI – Drug-drug interaction

Field Type 1

Complera

Field Type 2

Proton pump inhibitors

References:

FDA Drug Safety Labeling Changes. January 2013. Available at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm318602.htm>

2. Use of Prozac (fluoxetine) in patients treated with MAOIs

Message: In January 2013, the FDA updated the labeling of Prozac (fluoxetine). Prescribing Prozac to a patient who is being treated with MAOIs such as linezolid is contraindicated because of an increased risk of serotonin syndrome.

Exception Type: DDI – Drug-drug interaction

Field Type 1

Prozac

Field Type 2

MAOIs

References:

FDA Drug Safety Labeling Changes. January 2013. Available at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm338233.htm>

3. Use of Symbyax (olanzapine/fluoxetine) in patients treated with MAOIs

Message: In January 2013, the FDA updated the labeling of Symbyax (olanzapine/fluoxetine). Prescribing Symbyax to a patient being treated with MAOIs such as linezolid is contraindicated because of an increased risk of serotonin syndrome. The use of MAOIs with Symbyax or within 5 weeks of stopping treatment with Symbyax is contraindicated because of an increased risk of serotonin syndrome. It is contraindicated to start Symbyax within 14 days of stopping an MAOI.

Exception Type: DDI- Drug-drug interaction

Field Type 1

Symbyax

Field Type 2

MAOIs

References:

FDA Drug Safety Labeling Changes. January 2013. Available at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm254819.htm>

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

Message: In February 2013, 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 Type 1

Perindopril

Prinivil

Prinzide

Field Type 2

aliskiren

Field Type 3

Diabetes

References:

FDA Drug Safety Labeling Changes. February 2013. Available at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm239914.htm>

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm283115.htm>

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm342981.htm>

5. Use of Wellbutrin (bupropion) and Wellbutrin SR (bupropion) Sustained-Release in patients taking drugs that inhibit the reuptake of dopamine or norepinephrine or inhibit their metabolism

Message: In March, the FDA updated the labeling of Wellbutrin and Wellbutrin SR (bupropion). Prescribing these medications to a patient MAOIs is contraindicated because of an increase in hypertensive reactions. The use of Wellbutrin within 14 days of stopping treatment with an MAOI is also contraindicated. Starting Wellbutrin in a patient treated with reversible MAOIs is contraindicated.

Exception Type: DDI- Drug-drug interaction

Field Type 1

Wellbutrin

Wellbutrin SR

Field Type 2

MAOIs

References:

FDA Drug Safety Labeling Changes. March 2013. Available at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm267296.htm>

Appendix

[Insert Current Date]

Medicaid Provider: [Provider First Name] [Provider First Name]

Patient Name: [Patient First Name] [Patient Middle Name] [Patient Last Name]

Medicaid ID Number: [Recipient ID] **Patient Date of Birth:** [Patient Date of Birth]



As the drug utilization review vendor for Mississippi Medicaid, MS-DUR reviews pharmacy claims for Medicaid beneficiaries to offer providers feedback on their patients using Medicaid's pharmacy and medical claims data. Many Medicaid providers value this service because it helps them identify potential issues which can be identified from their patient's pharmacy and medical claims. Your patient listed above has been identified as having a diagnosis for coronary artery disease (CAD) without a pharmacy claim for a lipid lowering therapy. This notice is simply for your information and no action is required on your part, but it might be useful to include this sheet in your patient's chart (or document in their electronic medical record, if applicable) to discuss with this patient during their next visit.

THE OBJECTIVE

The objective of this initiative is to increase appropriate prescribing of lipid lowering therapies in Medicaid beneficiaries with coronary artery disease (CAD).

HOW WERE PATIENTS IDENTIFIED?

Patients were selected based on the presence of ICD-9 codes in the Medicaid medical claims data for CAD (including acute myocardial infarction, angina pectoris, and other forms of ischemic heart disease) and the absence of lipid lowering therapy in the Medicaid prescription claims history. Please note that some patients identified may be paying cash or using a prescription plan other than Medicaid to receive their lipid lowering therapy. No access to clinical history or patient charts was utilized during this assessment, so patient LDLs are unknown to MS-DUR and to Medicaid.

THE EVIDENCE

According to treatment guidelines, patients with CAD should try to achieve low-density lipoprotein (LDL) levels of **less than 100 mg/dL**.¹ A reduction in LDL cholesterol, regardless of the specific number, has been shown to **decrease mortality** in CAD over a five year period.¹ Statins are the **preferred agents** to lower LDL levels, but **non-statin lipotropics** can be used if the patient has contraindications to statins or needs combination therapy.¹ Following a recommendation by the Mississippi Medicaid DUR Board, Medicaid requires a 30 day trial with a statin or statin combination product in the past year before a non-statin lipotropic agent will be approved. Exceptions are made in cases of pregnancy, liver disease, hypertriglyceridemia, or current treatment with a preferred bile acid sequestrant.

An analysis conducted by MS-DUR using national Medicaid data found that Mississippi had the second to lowest proportion of beneficiaries with CAD who were treated with lipid lowering therapy. For more information, please see the Medicaid preferred drug list at www.medicaid.ms.gov/Pharmacy.aspx.

Sincerely,

Kyle D. Null, PharmD, PhD
Clinical Director, MS-DUR

¹ Pflieger M, Winslow BT, Mills K, Dauber IM. Medical Management of Stable Coronary Artery Disease. Am Fam Physician. 2011 April. [cited 2013 April]. <http://www.aafp.org/afp/2011/0401/p819.html>