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

MISSISSIPPI DIVISION OF
MEDICAID

February 5, 2015 at 2:00pm

Woolfolk Building, Room 117

Jackson, MS

Prepared by:

MS | DUR Evidence-Based DUR Initiative
The University of Mississippi School of Pharmacy

Drug Utilization Review Board

Allison Bell, Pharm.D.
University of MS School of Pharmacy
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Term Expires: June 30, 2015

James R. “Beau” Cox, Pharm.D. **(Co-Chair)**
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Term Expires: June 30, 2017

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Dennis Smith, R.Ph. **(Chair)**
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Term Expires: June 30, 2017

Cynthia Undesser, M.D.
MS Children's Home Services
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Jackson, MS 39202
Term Expires: June 30, 2017

2015 DUR Board Meeting Dates

February 5, 2015
May 7, 2015
August 6, 2015
November 5, 2015

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 pharmacy benefits are included in the analyses. When appropriate, reports include analyses comparing the Medicaid fee-for-service (FFS) and the two MississippiCAN plans. Further, reported dollar figures represent reimbursement to providers and are not representative of overall Medicaid costs. Any reported enrollment data are presented are unofficial and are only for general information purposes for the DUR Board.

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

http://www.medicaid.ms.gov/providers/pharmacy/preferred-drug-list/

MISSISSIPPI DIVISION OF MEDICAID

OFFICE OF THE GOVERNOR

DRUG UTILIZATION REVIEW BOARD

AGENDA

February 5, 2015

DUR Board Meeting Minutes

MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE AUGUST 21, 2014 MEETING

DUR Board Members:	Present	Absent
Allison Bell, Pharm.D.	✓	
James R. "Beau" Cox, Pharm.D.	✓	
Logan Davis, Pharm.D.	✓	
Lee Greer, M.D.		✓
Antoinette M. Hubble, M.D.	✓	
Sarah Ishee, Pharm.D.	✓	
Cherise McIntosh, Pharm.D.	✓	
Jason Parham, M.D.	✓	
Bobby Poctor, M.D.	✓	
Sue Simmons, M.D.	✓	
Dennis Smith, R.Ph. (Chair)	✓	
Cynthia Undesser, M.D.	✓	
Total	**11**	**1**

Also Present:

DOM Staff:
Judith Clark, R.Ph., DOM Pharmacy Bureau Director; Shannon Hardwick, R.Ph., DOM Clinical Pharmacist, DUR Coordinator; Terri Kirby, R.Ph., DOM Clinical Pharmacist

MS-DUR Staff:
Ben Banahan, Ph.D., Project Director; Sujith Ramachandran, Analyst; Divya Verma, Analysts; Sasi Nunna, Analyst; Zainab Shahpurwala, Analyst

Xerox Staff:
Leslie Leon, Pharm.D.

MS-CAN Staff:
Conor Smith, R.Ph., Magnolia; Resheeda Rhymes, R.N., United Healthcare

Visitors:
Darlene Bitel, Shire; Amy Taybor, MedImmune; Evelyn Joforn, Capital Resources; Bob Firnberg, Gilead

Call to Order: Mr. Dennis Smith, Chairman of the Board, called the meeting to order at 2:00pm.

Mr. Smith asked for a motion to accept the minutes from the meeting of May 15, 2014. Dr. Undesser made a motion to accept the minutes with a second from Dr. Hubble. All voted in favor of the motion.

Pharmacy Program Update:

Due to a scheduling conflict, Ms. Clarke asked that the Pharmacy Program Update be moved before the Resource Utilization Review on the agenda. Ms. Clarke thanked the board members who have been

reappointed and serve another term. She explained the recent reversal on the pharmacy reimbursement methodology and stated that starting September second, Xerox will be adjusting claims that were paid under the NADAC reimbursement methodology. She asked that pharmacies be patient with DOM while these adjustments are being made.

Ms. Clarke pointed out that the new palivizumab prophylaxis treatment guidelines will be discussed later in the meeting. She wanted the board to know that DOM has been in touch with the Mississippi Academy of Pediatrics and has gotten their approval for DOM to continue following the AAP guidelines. She also pointed out that we are moving forward with development of a uniform PDL and the DOM DUR will be working closely with the MSCAN partners in implementing the uniform PDL.

Ms. Hardwick pointed out the in addition to the usual travel form there was a contact information sheet that needed to be updated and the annual conflict of interest form that needed to be completed. She also informed the DOM and MS-DUR staff had just been notified that their abstract, "Savings from Implementing a Tablet Splitting Criteria for Aripiprazole in a State Medicaid Program**,"** was accepted for presentation in October at the Academy of Managed Care Pharmacy meeting in Boston.

Election of Officers:

Dr. McIntosh made motion that officers remain the same (Dennis Smith, Chair and Beau Cox, Co-Chair). Dr. Simmons seconded. The motion passed unanimously.

Resource Utilization Review:

Dr. Banahan pointed out some new resource utilization reports that have been added to the board packet. As mentioned at the last board meeting, MS-DUR will be working to expand most of the Resource Reports to include comparable data for the two MSCAN plans. Dr. Banahan pointed out that overall enrollment in Medicaid has increased more than 30,000 beneficiaries in the last year as a result of healthcare reform. He also reviewed differences between fee-for-service (FFS) and the two MS-CAN plans on several of the per prescription and per beneficiary measures being and noted that when reviewing many of these metrics it will be important to remember that the FFS and MS-CAN populations are very different. Dr. Banahan reviewed the top 25 drug reports, pointing out that similar data for MS-CAN has been added. This report and several others will become important tools in monitoring consistent application of the uniform PDL once it goes into effect.

New Business:

Buprenorphine-Naloxone Utilization in FFS and MSCAN

Dr. Banahan discussed the utilization trends observed in FFS, Magnolia and United Healthcare. Based on the number of restarts for each beneficiary and the total number of days on therapy, it did not appear that any problems would exist in making the current FFS treatment guidelines the guidelines for the uniform PDL. Dr. McIntosh made a motion that with MS-DUR recommendation 2 being amended to read "As practical, implementation of the DOM buprenorphine-naloxone treatment guidelines in the uniform PDL should treat movement across plans as transparently as possible, with all previous use being taken into account by the new plan," recommendations 1 ("The current DOM buprenorphine-naloxone treatment guidelines should be incorporated into the uniform PDL in order to maximize consistency across plans") and 2 should be approved. The motion was seconded by Dr. Davis and unanimously approved. The Board expressed desire for MS-DUR to conduct educational outreach for providers about implementation in uniform PDL and the transparency across plans.

Uniform PDL Compliance Monitoring
Dr. Banahan described how the new PDL Compliance Monitoring analysis will help to monitor consistent application of the uniform PDL and provide early detection of potential problems that might arise after PDL changes. Dr. Ishee made a motion for approval of the MS-DUR recommendation that an analysis of the uniform PDL compliance and issues identified in this analysis be reported to the DUR Board at its quarterly meetings for review and suggestions regarding the uniform PDL. The motion was seconded by Dr. Parham and approved unanimously. Dr. Banahan then reviewed with the board the proposed follow-up analysis that will be conducted by MS-DUR monthly on non-preferred drug use. Examples were provided of how this internal report will be used to identify electronic and manual PA procedures that need correcting.

Zohydro ER Utilization Management Criteria
Dr. Banahan introduced the Zohydro ER report and explained that there were two sets of recommendations – one for the board to assert that drug specific criteria needed to be developed and if that motion was passed, board input and approval of specific criteria to be implemented by DOM. Ms. Hardwick provided a background and explained why drug specific criteria were considered necessary. After some discussion, Dr. McIntosh recommended approval of the MS-DUR recommendation that drug specific criteria be developed. The motion was seconded by Dr. Proctor and passed unanimously. Ms. Hardwick then reviewed with the board draft criteria that had been developed by DOM and MS-DUR. After discussion and suggestions were incorporated, Dr. McIntosh recommended that the following criteria be implemented for prior authorization of Zohydro:

Age edit	Minimum age of 18 years
Quantity limit	Maximum 2 units per day, 62 tablets in 31 days
Diagnosis	Documented diagnosis of cancer
Step-therapy	Prior 30 days of therapy with 3 different preferred agents in the past 12 months AND Prior 30 days of therapy with 2 different non-preferred agents in the past 12 months

The motion was seconded by Dr. Undesser and approved unanimously. The board also asked that MS-DUR monitor use of this drug and report back to the board in 18 months.

Xartemis XR Utilization Management Criteria
Ms. Hardwick discussed the concerns about Xartemis XR. Dr. McIntosh made a motion for approval of the MS-DUR recommendation that drug-specific PA criteria be developed for this drug. The motion was seconded by Dr. Proctor and approved unanimously. Ms. Hardwick reviewed the draft criteria that had been developed. After discussion and suggested changes were incorporated, Dr. McIntosh recommended the following criteria be implemented for prior authorization of Xartemis XR:

Age edit	Minimum age of 18 years
Quantity limit	40 tablets in 10 rolling days
Step-therapy	Prior 5 days of therapy with 2 different preferred agents in the past 30 days
Duration of therapy	Limited to 20 days of therapy per calendar year

The motion was seconded by Dr. Hubble and approved unanimously.

Updated Guidelines for Palivizumab Prophylaxis Use
Dr. Banahan pointed out that the summary of the new palivizumab RSV prophylaxis guidelines was included in everyone's folder since the guidelines were distributed too close to when the board packets had to be mailed. He reviewed the new guidelines recommended by the American Academy of Pediatrics and apologized that the summary could not be prepared in time for inclusion in the packet (new guidelines attached as appendix to minutes). As in the past, the recommended DOM guidelines are consistent with those recommended by AAP. Dr. Ishee made a motion that the recommended new guidelines be adopted by DOM. The motion was seconded by Dr. Simmons and approved unanimously.

Exceptions Monitoring Criteria Recommendations
Dr. Banahan introduced the three new exceptions monitoring criteria that were being proposed. All three criteria are based on recent warnings or updates from the Food and Drug Administration. Dr. Parham made a motion that the three new exceptions be approved as a group. The motion was approved by Dr. Bell and passed unanimously.

Other Business

Dr. Hubble pointed out to DOM that limitations on ADHD medications were a problem with the MS-CAN formularies and that this needs to be considered in developing the uniform PDL. Dr. Undesser pointed out that it is also a problem with PAs for non-preferred antipsychotics when the medication is started during a hospital stay. The DOM FFS plan allows for PA of these non-preferred agents, but this practice was not uniformly done with the MS-CAN plans.

Next Meeting Information:

Mr. Smith announced that the next meeting date is November 20 at 2:00p.m. Ms. Hardwick reminded everyone that the November meeting will be in ROOM 138 rather than the usual room. Mr. Smith thanked everyone for making the effort to attend the DUR Board meeting and for the lively discussions. The meeting adjourned at 3:30pm.

Submitted,
Evidence-Based DUR Initiative, MS-DUR
Benjamin F. Banahan, III, Ph.D., Project Director

APPENDIX

2014-15 Division of Medicaid
Palivizumab Prophylaxis Prior Authorization Criteria*

Beneficiaries must meet one of the bullet point criteria for age at beginning of the RSV season.

Age ≤ 1 year at start of RSV season and one of the following:	**Age 12 – 24 months at start of RSV season and one of the following:**
- Prematurity of ≤ 28 weeks 6 days gestation - Documentation of **chronic lung disease** (CLD) of prematurity defined as gestational age of 29 weeks 0 days – 31 weeks 6 days **AND** requirement for oxygen >21% for at least the first 28 days after birth. - Documentation of **hemodynamically significant CHD AND** one of the following: (1) **acyanotic heart disease** receiving medication for congestive heart failure **AND** will require cardiac surgery. (2) **moderate to severe pulmonary** hypertension. (3) Documentation of **cyanotic heart disease** through consultation with pediatric cardiologist. - Documentation of **congenital abnormalities of the airway OR neuromuscular disease** that impairs the ability to clear secretions from the upper airway because of ineffective cough. - Documentation of **cystic fibrosis AND** clinical evidence of CLD **OR** nutritional compromise. - Documentation of **profound immunocompromise** during the RSV season.	- Documentation of **chronic lung disease** (CLD) of prematurity defined as gestational age of 29 weeks 0 days – 31 weeks 6 days **AND** requirement for oxygen >21% for at least the first 28 days after birth **AND** required continued medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the RSV season. - Documentation of **cystic fibrosis AND** one of the following: (1) manifestations of **severe lung disease** (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest compute tomography that persists when stable). (2) weight for length < 10th percentile. - Documentation of **profound immunocompromise** during the RSV season.

Coverage limitations:
- Authorization will be granted for administration between October 31 and March 31.
- Coverage is up to five doses, but will be less for infants born during the RSV season.
- Monthly prophylaxis should be discontinued for any infant or young child experiencing a breakthrough RSV hospitalization.

NOTES:
- Prophylaxis in infants with Down Syndrome is not recommended without the presence of one of the criteria listed above.

** Criteria based 2014 AAP guidance. DOI: 10.1542/peds.2014-1665.*

MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE November 20, 2014 MEETING

DUR Board Members:	Present	Absent
Allison Bell, Pharm.D.		✓
James R. "Beau" Cox, Pharm.D.		✓
Logan Davis, Pharm.D.	✓	
Lee Greer, M.D.		✓
Antoinette M. Hubble, M.D.	✓	
Sarah Ishee, Pharm.D.		✓
Cherise McIntosh, Pharm.D.	✓	
Jason Parham, M.D.	✓	
Bobby Proctor, M.D.	✓	
Sue Simmons, M.D.		✓
Dennis Smith, R.Ph. (Chair)	✓	
Cynthia Undesser, M.D.		✓
Total	**6**	**6**

Also Present:

DOM Staff:
Judith Clark, R.Ph., DOM Pharmacy Bureau Director; Shannon Hardwick, R.Ph., DOM Clinical Pharmacist, DUR Coordinator; Terri Kirby, R.Ph., DOM Clinical Pharmacist

MS-DUR Staff:
Ben Banahan, Ph.D., Project Direct

Xerox Staff:
Leslie Leon, Pharm.D.

Visitors:
Mark Stephens, Pfizer; Tim Hambacher, Otsuka; Walter Lawhorn, Otsuka; Bob Firnbey, Gilead; Lee Ann Mayo, Capital Resources; Conor Smith, Magnolia Health Care; Lori Martin, Medimmune

Call to Order: Mr. Dennis Smith, Chairman of the Board, called the meeting to order at 2:00 pm.

No quorum. Mr. Smith deferred approval of minutes from the meeting of August 21, 2014 to the next meeting when a quorum was present.

Resource Utilization Review:
Dr. Banahan pointed out that data anomalies have been corrected with the MSCAN encounter data and that the summary tables at the beginning of the report should more accurately reflect trends among the three pharmacy plans. MS-DUR still has some concerns about the large number of reversals that were required because of the reimbursement methodology change in August, but believe that most of these have now been incorporated into the data set. The most significant changes in products based on number of prescriptions and amount paid were attributed to seasonal allergies, ADHD children returning

to school, and continued uptake on the new HEP-C products. No unexpected findings were detected. MS-DUR will continue work on developing more detailed summaries for the three plans.

Pharmacy Program Update:
Ms. Hardwick reported that Zohydro® ER and Xartemis® XR criteria approved by the Board at the last meeting have been implemented. The new Synagis® PA form is on-line. Since the Synagis® season has just started there is not an update on how the new guidelines are affecting utilization. MS-DUR will report on this at the February meeting. She pointed out that a Division of Medicaid (DOM) brand preferred list was included in the packet and will be posted to the web. DOM will update this list as changes occur in order to help providers identify situations where brands are preferred over generics due to supplemental rebates. It was reported that work on the Uniform PDL is continuing and it is scheduled to be implemented January 1, 2015. Ms. Hardwick reviewed the criteria related to 72-hour emergency prior authorization (PA) policy and explained the purpose of the 72-hour PA. She noted that a sheet had been included in member's folders that summarized the 72-hour PA procedures for each of the three pharmacy plans. She noted that when possible, summary sheets like this would be developed and posted to the DOM web site to help providers more easily manage patients in the three plans.

Ms. Clark commented that the 72-hour emergency PA sheet is an example of how DOM and MSCAN plans are working together to make procedures, etc. more uniform and to provide information from all 3 plans together. Mr. Smith asked if MSCAN plans have same turnaround requirement for PAs as does the FFS plan. He reported that FFS has generally been same day where as MSCAN plans have been much longer. Ms. Clark indicated this and other issues were being addressed in the new MSCAN contracts and in the development of the uniform PDL. Ms. Clark discussed efforts being made to develop a uniform PDL that is robust enough for special need groups.

New Business:
Metabolic Screening for Children on Antipsychotics
Dr. Banahan reviewed the quality measure being developed by the Centers for Medicare and Medicaid Services (CMS) for use in Medicaid children programs. He reported results from the MS-DUR analysis for Mississippi Medicaid. In the last fiscal year, Mississippi Medicaid performed at about the 25th percentile on this quality measure. Performance did not significantly differ among the three pharmacy plans. MS-DUR recommended that an educational program be undertaken on the importance of metabolic monitoring for children taking antipsychotics and that exception monitoring be done with targeted mailings to providers on this topic for the next six months. Due to a lack of quorum, no vote was taken but considerable discussion occurred with support for the recommendation. The Board recommended that the educational effort provide the diagnostic codes needed. They also discussed the fact that a clinical edit may be required to significantly address this issue. Dr. Banahan reported that MS-DUR would go ahead and initiate the educational intervention plan and would report back to the Board at the May 2015 meeting with how effective the intervention has been and to discuss further actions needed, if any.

Use of Opioids at Higher Doses in Persons Without Cancer – Morphine Equivalent Dose Limits
Dr. Banahan discussed the difference between the MS-DUR efforts to work with DOM Program Integrity to identify potential abusers of narcotics that used high dose measures combined with doctor/pharmacy shopping measures and the current analysis focusing on identifying beneficiaries at risk of developing addiction. MS-DUR recommended that DOM implement an electronic PA clinical edit to prevent long term use of narcotics at higher morphine equivalent doses in order to prevent addiction. The board discussed the importance of prevention measures and support for a criteria of a morphine equivalent

dose of 100 or more for 60 consecutive days. Since there was no quorum, a vote was not taken on the motion. MS-DUR will bring the recommendation back to the Board at the February meeting.

Oral Birth Control Pills Restriction to Birth Control
Dr. Banahan provided the Board background on how Medicaid programs could receive a higher Federal match on contraceptives through the Family Planning, Access, Care and Treatment (FPACT) Program when the products were used for birth control. He reported that the Department of Health and Human Services Office of the Inspector General (OIG) has been auditing states to be sure claims for the higher match rate were actually for birth control. During these audits, OIG has determined that documentation needed to be in the medical claims that actually documented the use of the products for birth control. MS-DUR conducted an analysis to determine how much additional documentation was needed in order for DOM to maximize the number of claims eligible for the higher match rate. Results indicated that the number of claims with documentation could be significantly increased. MS-DUR recommended that DOM implement an electronic PA clinical edit that would require appropriate documentation of contraceptive counseling in the medical records within one year of a prescription being filled for contraceptives. After discussion, the Board recommended that a look back period be set based on what was acceptable to the OIG. No vote was taken due to a lack of a quorum.

Weight Loss Clinical Edit for Naltrexone and Buproprion Combination
Dr. Banahan informed the Board that Contrave®, a combination product containing naltrexone and buproprion, had recently been approved for chronic weight management. As required by Federal guidelines, DOM does not cover weight loss products and thus would not be covering Contrave®. In a recent newsletter, Xerox recommended that Medicaid programs consider an electronic clinical edit that would prevent concomitant use of the individual products. MS-DUR analysis found that only one case of concomitant use has occurred in 2014. MS-DUR recommended that DOM go ahead and follow the Xerox recommendation and implement a clinical edit to prevent concomitant use of the two products without a manual PA. During discussion it was clarified that the clinical edit would only address concomitant use and would have no impact on individual use of the two products. No vote was taken due to a lack of quorum.

Exceptions Monitoring
Dr. Banahan noted that all recommended exceptions are from FDA notices. These recommendations will be added to new ones for the next meeting and a Board vote will be taken at that time.

Other Business
There was no other business.

Next Meeting Information:

Mr. Smith announced next meeting date is February 5, 2015 at 2:00p.m. He thanked everyone for making the effort to attend the DUR Board meeting and wished everyone a happy holiday. The meeting adjourned at 3:20 pm.

Submitted,
Evidence-Based DUR Initiative, MS-DUR

Old Business

ANTIPSYCHOTIC QUALITY MEASURES: METABOLIC MONITORING IN CHILDREN TAKING ANTIPSYCHOTICS

ABBREVIATED SUMMARY FROM NOVEMBER BOARD PACKET – TABLE NUMBERS HAVE REMAINED THE SAME EVEN THOUGH NOT ALL TABLES ARE INCLUDED

BACKGROUND

Increasing concerns regarding obesity and diabetes emergence in younger populations[1] are heightened for youth prescribed antipsychotic medications due to adverse metabolic and other physical effects[2] A multi-year study of youth enrolled in three health maintenance organizations found that exposure to atypical antipsychotics was associated with a fourfold risk of diabetes in the following year, compared to children not prescribed psychotropic medication[3].

The current report focuses on the National Collaborative for Innovation in Quality Measurement (NCINQ) measure - metabolic screening for children on antipsychotics.

METHODS

A retrospective analysis was conducted using Mississippi Medicaid medical and pharmacy claims data and beneficiary eligibility data for July 2013 through June 2014. Both fee-for-service (FFS) and managed care claims are used for the analysis. MS-DUR used the measure specifications provided by NCINQ in their April 2013 call for public feedback on proposed measures. This measure addresses "the percentage of children 0 to 20 years of age on any antipsychotic who had metabolic screening documented during the measurement year". Quality measures like this one are reported as percentages. In this case, higher numbers are better.

Denominator: The denominator contains beneficiaries between ages 0 and 21 as of June 30 2014, who were continuously enrolled for at least 3 months with medical and pharmacy benefits and were on any antipsychotic medication (Appendix Table 1).

The recommended measure included three numerators.

Numerator 1: Children and adolescents who had at least one test for blood glucose during measurement year (HbA1c test for children with diabetes and either HbA1c or blood glucose for children without diabetes) (Procedure codes listed in Appendix Table 2).

[1] Eisenmann JC. Secular trends in variables associated with the metabolic syndrome of North American children and adolescents: a review and synthesis. Am J Hum Biol. 2003 Nov-Dec;15(6):786-94. Review. PubMed PMID: 14595870.
[2] Pringsheim T, Lam D, Ching H, Patten S. Metabolic and neurological complications of second-generation antipsychotic use in children: a systematic review and meta-analysis of randomized controlled trials. Drug Saf. 2011 Aug 1;34(8):651-68. doi: 10.2165/11592020-000000000-00000. Review. PubMed PMID: 21751826.
[3] Andrade S, Lo J, Roblin D, Fouyazi H, Connor D, Penfold R, Chandra M, Reed G, Gurwitz J. (2011) antipsychotic medication use antipsychotic medication use among children and risk of diabestes mellitus. Pediatrics, 128, 1135-1141.

Numerator 2: Children and adolescents who had at least one cholesterol test during the measurement year (Procedure codes listed in Appendix Table 3).

Numerator 3: Children and adolescents who had both a test for blood glucose and cholesterol during the measurement year.

RESULTS

The percentage of children and adolescents enrolled in Medicaid taking antipsychotic medications who had at least one claim for a blood glucose and/or cholesterol tests are shown in Table 1.

Table 1: Metabolic Monitoring in Children Taking Antipsychotics

	Total Number of Beneficiaries (N= 8,912)	
	No of Beneficiaries	Percentage of Beneficiaries
Blood glucose test	2669	29.9%
Cholesterol test	1261	14.1%
Both tests	1162	13.0%

Table 3 shows performance rates on the three metabolic monitoring measures by health plan (Mississippi Medicaid fee-for-service (FFS), United Health Care (UHC), and Magnolia). The performance rates on the three measures does not meaningfully differ across the three plans in the Mississippi Medicaid program. This indicates that our current level of performance is primarily a factor of how practitioners in the state manage these patients.

Table 3 : Percent of Children Taking Antipsychotics Receiving Metabolic Monitoring By Health Plan

	FFS (Denominator = 6,163)		**UHC (Denominator = 1,101)**		**Magnolia (Denominator = 1,648)**	
Measure	Beneficiaries Having Test		Beneficiaries Having Test		Beneficiaries Having Test	
Blood glucose test	1,867	30.3%	311	28.3%	491	29.8%
Cholesterol test	892	14.5%	138	12.5%	231	14.0%
Both tests	824	13.4%	126	11.4%	212	12.9%

CONCLUSION

Based on the performance ratings for the last year, the Mississippi Medicaid program currently has a performance rating on metabolic monitoring for children taking antipsychotic medications that is barely above the 25th percentile for Medicaid programs. Since this is an important quality of care measure being developed by CMS, some action is needed to improve our performance on this measure.

A hard clinical edit in the pharmacy point-of-sale (POS) system cannot be used to achieve improvement in this area. Since metabolic monitoring can occur at any time during the year, MS-DUR believes that the only practical way to achieve improvement in performance on this quality measure will be through provider education.

Recommendation:

MS-DUR recommends the following actions be undertaken in order to achieve improvement in metabolic monitoring for children taking antipsychotics.

1. MS-DUR should prepare an educational article about the importance of metabolic monitoring in children taking antipsychotics for distribution in quarterly electronic mailing.

2. MS-DUR should include an exception monitoring routine that will identify beneficiaries who have failed to meet this performance criteria during the last month and send educational letters to the prescribers of the antipsychotic medications. This exception monitoring will be targeted for intervention mailings for the next 6 months at which time performance will be reevaluated and reported to the DUR Board.

3. United Health Care and Magnolia will be encouraged to undertake a similar educational intervention.

AT NOVEMBER MEETING: The Board agreed with the MS-DUR recommendations and suggested that the educational effort include information about the procedure codes needed to appropriately document follow-up care was received. They also expressed concern that education may not be sufficient and we may need to consider a clinical edit in the future.

USE OF OPIODS AT HIGHER DOSES IN PERSONS WITHOUT CANCER: MORPHINE EQUIVALENT DOSE EDIT

ABBREVIATED SUMMARY FROM NOVEMBER BOARD PACKET – TABLE NUMBERS HAVE REMAINED THE SAME EVEN THOUGH NOT ALL TABLES ARE INCLUDED

BACKGROUND:

Approximately 10% of patients who are prescribed opioids and seek care from multiple doctors, are prescribed high daily doses (≥100 mg morphine equivalent dose (MED) per day), and account for 40% of opioid overdoses.[1, 2] Patients exceeding this MED cut-off are at high risk for overdose themselves but may also be diverting or providing drugs to others who are using them without prescriptions. This suggests that prevention of opioid overdose deaths should focus on strategies that target (1) high-dose opioid users as well as (2) persons who seek care from multiple doctors, receive high doses, and are likely involved in drug diversion.[3] The combination of these two criteria provides a good method for identifying beneficiaries at risk of opioid abuse and risk or overdose death. The first criteria - high-dose opioid use - is a safety issue, whereas, the second criteria – use of multiple providers – is an indicator of potential abuse.

In line with these aforementioned groups, three draft measures have been proposed by the Pharmacy Quality Alliance's (PQA) Medication Safe Use Workgroup to examine the quality of opioid use related to the dose of the medications over time, access to the medications, and the combination of both of these criteria.[3]

- **Measure 1 (Opioid Dose Over-utilization):** The percentage of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 days or longer.
- **Measure 2 (Multiple Providers and Multiple Pharmacies):** The percentage of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.
- **Measure 3 (Multi-Provider, Multi-Opioid Use):** The percentage of individuals without cancer receiving prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 days or longer, who received opioid prescriptions from four (4) or more prescribers, AND four (4) or more pharmacies.

Based on growing concerns about preventing opioid related deaths due to high doses, MS-DUR reran analyses focusing on Measure 1 – high-dose utilization. This is a clinical safety issue that could be addressed through prospective clinical edits, whereas, the multiple provider measures are not easily addressed prospectively. The purpose of this analysis was to determine the number of

[1] Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose. Ann Intern Med 2010;152:85–92.
[2] Bohnert AS, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. JAMA 2011;305:1315–21.
[3] PQA Medication Safe Use Workgroup. Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer.

beneficiaries who are possibly over-utilizing opioid medications in the Medicaid population and are at-risk for opioid addiction or death.

METHODS:

Medicaid fee-for-service (FFS) and managed care (MS-CAN) claims for the period July 1, 2013 and June 30, 2014 were used in the analysis. Beneficiaries aged ≥18 years, with continuous 12 month enrollment, and two or more prescription claims for opioids with ≥15 days supply on at least two separate dates during the measurement period were included in the analysis. Beneficiaries with Prescription Drug Hierarchical Condition Categories (Rx-HCCs) 8, 9, 10, 11 were excluded from the final sample (representing patients with cancer diagnoses). Claims for all opioids included in the 'CDC Injury Center Morphine Milligram Equivalent (MME) Table' (Appendix) were extracted.

Morphine Equivalent Dose (MED) was calculated using the following formula:

$$MED = \frac{Submitted\ Quantity \times Strength \times MME\ Conversion\ Factor}{Days\ Supply}$$

The quality measure used in this analysis is the percentage of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 days or longer. Sensitivity testing was conducted by using 100mg MED in addition to 120mg and by using 60 days in addition to 90 days as the duration of high dosing required.

RESULTS:

Table 2 shows the number and percent of beneficiaries meeting the high dose criteria for the quality measure. Rates for FFS and Magnolia were similar. The rates for UHC were significantly higher than for the two other plans. The sensitivity analyses show that a more relaxed time criteria for high dosing (60 days vs. 90 days) almost doubles the percentage of beneficiaries identified as being at risk. Using the lower MED of 100mg increases the percentage of beneficiaries identified as being at risk by about 50%.

TABLE 2: Number and Percent of Beneficiaries With Opioid Use Exceeding the Morphine Equivalent Dose Limits

	60 Consecutive Days			90 Consecutive Days		
	FFS	**UHC**	**MAGNOLIA**	**FFS**	**UHC**	**MAG**
MED > 100	51 (2.1%)*	419 (5.6%)	227 (2.3%)	27 (1.1%)	301 (4.0%)	114 (1.1%)
MED > 120	39 (1.6%)	343 (4.6%)	167 (1.7%)	24 (1.0%)	243 (3.2%)	80 (0.8%)
*Example: (51/2475)*100 = 2.1%						

CONCLUSION:

The absolute percentage of beneficiaries identified as being at risk from use of high doses of opioids is small. This is good, but the fact that any beneficiaries without a cancer diagnosis were identified indicates that a problem still exists. Since managing opioid use and actively trying to prevent opioid addition is a high national priority, MS-DUR makes the following recommendations.

Recommendations:

1. DOM should implement an electronic prior authorization clinical edit to prevent beneficiaries from exceeding the morphine equivalent dose of 120mg/day for more than 90 days during the prior year.

2. United Health Care and Magnolia should be encouraged to implement a similar edit for Medicaid beneficiaries enrolled in Coordinated Care.

AT NOVEMBER MEETING: The board discussed the importance of prevention measures and supported a clinical edit for a morphine equivalent dose of 100 or more for 60 consecutive days.

USE OF CONTRACEPTIVE PRODUCTS IN MISSISSPPI MEDICAID FAMILY PLANNING WAIVER PROGRAM

ABBREVIATED SUMMARY FROM NOVEMBER BOARD PACKET – TABLE NUMBERS HAVE REMAINED THE SAME EVEN THOUGH NOT ALL TABLES ARE INCLUDED

BACKGROUND

In recent years, several states have expanded eligibility for Medicaid coverage of family planning services. Historically, states like MS have secured approval of a "waiver" of federal policy from the Centers for Medicare and Medicaid Services. Traditionally, MS Medicaid's Family Planning Program has been solely for women receiving family planning benefits. State Medicaid programs participating in the Family Planning, Access, Care and Treatment (FPACT) Program receive a 90% federal match for contraceptives used for family planning/birth control purposes.

Since the Division of Medicaid (DOM) can only receive the higher match amount for contraceptives having documentation of contraceptive counseling, it is important that DOM maximize the percentage of prescriptions that will qualify for the higher match. MS-DUR has conducted an analysis of contraceptive claims in the Mississippi Medicaid program to determine how often documentation might be lacking that these prescriptions were for family planning.

METHODS

A retrospective analysis was conducted using Mississippi Medicaid fee-for-service and managed care pharmacy claims data for the period January 2014 through September 2014 and medical (outpatient) claims data for the period January 2012 through September 2014. Beneficiaries having prescription claims for oral contraceptives during 2014 were identified. Medical claims with diagnosis codes related to general counseling and advice on contraceptive management (V25.0x), surveillance of previously prescribed contraceptive methods (V25.4x), pain and other symptoms associated with female genital organs (625.xx), Disorders of menstruation and other abnormal bleeding from female genital tract (626.xx), and for diseases of sebaceous glands (706.xx) were extracted for these beneficiaries. Analyses were conducted to determine which diagnoses were documented in medical claims prior to the first pharmacy claims for an oral contraceptive. A sensitivity analysis was performed for different lengths of look-back periods to determine how periods of 90 days, 365 days and 730 days would affect the percentage of oral contraceptive claims that could be documented as being for contraceptive use or other treatments.

RESULTS

Table 1 shows the percentage of beneficiaries taking oral contraceptives that had documentation of the treatments described above. As would be expected, the percentage of beneficiaries with a documented diagnosis increased as the length of the look-back period increased. Even with a two-

year look-back period, only about one-fourth of the beneficiaries taking oral contraceptives had documentation of contraceptive counseling. The prevalence of documentation was similar across all three plans.

TABLE 1: Percentage of Beneficiaries Taking Oral Contraceptives and Having Diagnosis Codes Found In Medical History Before First Oral Contraceptive Prescription Fill in 2014

Length of Procedure Code Look-back**	Codes Found	Medicaid Plan			
		Total (n = 18,617)	FFS (n = 9.555)	UHC (n = 4,231)	Magnolia (n = 4,831)
90 days	Contraceptive Counseling (CC) Only*	8.7%	9.4%	7.0%	8.5%
	CC + other*	1.6%	1.8%	1.1%	1.5%
	Menstrual only	9.4%	9.0%	8.9%	10.7%
	Acne only	0.6%	0.8%	0.3%	0.5%
	None	79.8%	79.0%	82.6%	78.8%
365 days	Contraceptive Counseling (CC) Only*	12.7%	14.4%	10.4%	11.6%
	CC + other*	4.5%	4.3%	4.5%	5.2%
	Menstrual only	18.2%	13.4%	23.2%	23.3%
	Acne only	1.3%	1.8%	0.5%	1.1%
	None	63.2%	66.2%	61.4%	58.8%
730 days	Contraceptive Counseling (CC) Only*	14.0%	15.6%	11.6%	12.8%
	CC + other*	8.4%	7.3%	9.3%	9.6%
	Menstrual only	21.1%	15.9%	26.7%	26.3%
	Acne only	1.9%	2.6%	0.9%	1.4%
	None	54.6%	58.4%	51.5%	40.8%

** A contraceptive counseling procedure code is required to document use for birth control.*
*** Look-back is from first oral contraceptive fill in 2014.*

CONCLUSIONS

Even with a two-year look-back period, only a small percentage of oral contraceptive use could be documented as being for birth control. Although the claims processing system can do a two-year look-back, contraceptive counseling should be expected more often. In order to maximize the number of contraceptive claims that qualify for the higher FMAP rate, DUR initiatives need to be undertaken to assure documentation of medical use for contraceptives.

RECOMMENDATION:

1. DOM should implement an electronic prior authorization clinical edit for all contraceptives (oral, injectable, or implant) requiring a diagnosis code for counseling and advice on contraceptive management (V 25.0x) or surveillance of previously prescribed contraceptive methods (V25.4x) be found in the medical claims history within one (1) year of a

prescription being filled or the diagnosis must be written on the prescription by the prescribing physician and entered by the pharmacy at the time of dispensing.

2. United Health Care and Magnolia should be encouraged to implement a similar edit for Medicaid beneficiaries enrolled in Coordinated Care.

AT NOVEMBER MEETING: The Board agreed with the MS-DUR recommendations and recommended that a look back period be set based on what was acceptable to the OIG. They also suggested that education may be needed about the diagnosis/procedure codes required to document that a contraceptive is for birth control purposes.

Resource Utilizaton Review

ENROLLMENT STATISTICS FOR LAST 6 MONTHS July 1, 2014 through December 31 - 2014							
			Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Total enrollment			712,969	717,802	721,644	723,769	723,990	704,104
Dual-eligibles			154,075	154,167	154,260	154,195	154,116	151,814
Pharmacy benefits			612,457	617,557	620,887	622,600	622,199	639,145
	LTC		17,681	17,643	17,631	17,588	17,373	16,925
	PLAN %	FFS	74.7%	74.5%	74.4%	74.5%	74.3%	71.0%
		MSCAN-Magnolia	11.5%	11.6%	11.6%	11.6%	11.6%	13.7%
		MSCAN-Magnolia	13.8%	13.9%	14.0%	13.9%	14.1%	15.3%

PHARMACY UTILIZATION STATISTICS FOR LAST 6 MONTHS July 1, 2014 through December 31, 2014							
		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
# Rx Fills	FFS	217,352	251,916	261,694	274,771	254,708	298,667
	MSCAN-UHC	104,433	109,268	111,951	114,211	106,802	78,083
	MSCAN-Mag	135,718	143,837	148,635	151,477	145,417	152,330
# Rx Fills / Bene	FFS	0.5	0.5	0.6	0.6	0.6	0.7
	MSCAN-UHC	1.5	1.5	1.6	1.6	1.5	0.9
	MSCAN-Mag	1.6	1.7	1.7	1.7	1.7	1.6
$ Paid Rx	FFS	$20,886,854	$22,376,408	$23,255,637	$24,469,213	$21,695,403	$27,165,449
	MSCAN-UHC	$6,465,296	$7,761,182	$7,882,223	$7,972,489	$7,576,571	$5,778,797
	MSCAN-Mag	$7,675,675	$7,095,109	$7,535,328	$9,232,983	$10,274,001	$11,016,186
$ /Rx Fill	FFS	$96.10	$88.82	$88.87	$89.05	$85.18	$90.96
	MSCAN-UHC	$61.91	$71.03	$70.41	$69.80	$70.94	$74.01
	MSCAN-Mag	$56.56	$49.33	$50.70	$60.95	$70.65	$72.32
$ /Bene	FFS	$45.65	$48.64	$50.34	$52.75	$46.93	$59.86
	MSCAN-UHC	$91.79	$108.34	$109.44	$110.58	$105.16	$66.00
	MSCAN-Mag	$90.82	$82.65	$86.69	$106.54	$116.94	$112.65

NOTE: Paid amounts represent amount reported on claims as paid to the pharmacy. These amounts do not reflect final actual costs after rebates, etc.

TOP 10 DRUGS BY CHANGE IN DOLLARS PAID September, 2014 TO November, 2014

Generic Molecule	Sep 2014 $ Paid	Oct 2014 $ Paid	Nov 2014 $ Paid	Sep 2014 # Claims	Oct 2014 # Claims	Nov 2014 # Claims	Sep 2014 # Benes	Oct 2014 # Benes	Nov 2014 # Benes
Oseltamivir	$46,163	$115,832	$599,221	272	650	3,219	267	647	3,215
Palivizumab	$0	$49,279	$89,116	0	24	48	0	19	35
Azithromycin	$286,647	$328,055	$366,075	8,706	9,779	10,980	8,555	9,593	10,789
Cefdinir	$237,899	$268,519	$291,584	2,905	3,265	3,471	2,856	3,219	3,428
Budesonide	$650,433	$716,979	$701,628	1,474	1,634	1,577	1,448	1,609	1,547
Amoxicillin-Clavulanate	$305,555	$341,852	$351,695	4,878	5,234	5,413	4,795	5,156	5,341
Corticotropin	$0	$66,799	$33,401	0	2	1	0	2	1
Cefixime	$116,497	$120,843	$148,719	316	322	420	314	320	417
Ondansetron	$241,003	$283,946	$271,814	2,432	2,711	2,624	2,377	2,641	2,560
Brompheniramine/ Dextromethorph/Phenylephrine	$62,431	$78,988	$92,228	7,568	9,469	10,903	7,422	9,268	10,671

Only drugs with > $500 paid (amount reimbursed to pharmacy) in last month are included in detail listing

TOP 10 DRUGS BY CHANGE IN NUMBER OF CLAIMS September, 2014 TO November, 2014

Generic Molecule	Sep 2014 $ Paid	Oct 2014 $ Paid	Nov 2014 $ Paid	Sep 2014 # Claims	Oct 2014 # Claims	Nov 2014 # Claims	Sep 2014 # Benes	Oct 2014 # Benes	Nov 2014 # Benes	Incr. # Claims
Brompheniramine/ Dextromethorph/Phenylephrine	$62,431	$78,988	$92,228	7,568	9,469	10,903	7,422	9,268	10,671	3,335
Oseltamivir	$46,163	$115,832	$599,221	272	650	3,219	267	647	3,215	2,947
Azithromycin	$286,647	$328,055	$366,075	8,706	9,779	10,980	8,555	9,593	10,789	2,274
Amoxicillin	$122,683	$135,880	$139,499	11,166	12,271	12,500	10,957	12,064	12,318	1,334
Codeine-Guaifenesin	$15,264	$20,409	$25,740	1,070	1,429	1,780	1,058	1,402	1,748	710
Brompheniramine-Phenylephrine	$16,037	$19,684	$21,692	1,954	2,387	2,612	1,919	2,351	2,582	658
Prednisolone	$90,713	$101,885	$98,424	5,678	6,381	6,253	5,503	6,162	6,084	575
Cefdinir	$237,899	$268,519	$291,584	2,905	3,265	3,471	2,856	3,219	3,428	566
Amoxicillin-Clavulanate	$305,555	$341,852	$351,695	4,878	5,234	5,413	4,795	5,156	5,341	535
Dextromethorphan-Guaifenesin	$3,893	$4,950	$5,447	719	912	1,016	710	901	1,000	297

Only drugs with > $500 paid (amount reimbursed to pharmacy) in last month are included in detail listing

Special Reports

Center for the Advancement of Youth

Coordinated care for youngsters with behavioral or developmental issues is offered at Center for the Advancement of Youth (CAY), a comprehensive diagnostic and treatment center devoted to promoting the healthy development of all Mississippi children and youth.

CAY combines telehealth technology, multidisciplinary health expertise and the support of statewide agencies to the advantage of young patients and their families. Its mission is to provide resources to fully support children and their families and provide the care they deserve, say executive director Dr. David Elkin and medical director Dr. Susan Buttross. The center's goal is to ensure that no child or youth ages birth to 25 suffers from lack of access to appropriate behavioral or developmental care and treatment.

By coordinating health services, the center's staff is able to walk parents and their children through what often can be a maze of services. Most young patients come to the clinic at the recommendation of their pediatricians, family doctors, school counselors or UMMC providers.

Listening carefully to the patient and parents is the first step at the center's clinic. From there, experts in behavior and health issues work together to develop a diagnosis. If additional tests are needed, the staff coordinates appointments to help ease the family's burden. For those who live away from the UMMC area, treatment plans often can be carried out by way of mobile health options at a regional clinic, doctor's office or school.

CAY multidisciplinary resources include experts in:

- Pediatrics
- Psychology
- Psychiatry
- Genetics
- Adolescent medicine
- Child abuse and neglect
- Neurology
- Family medicine
- Communicative services (hearing and speech therapy)
- Nursing
- Social work
- Education

Children's Center for the Advancement of Youth Home

Children

Children

Request Appointment

Online Appointment Request
or call 888-815-2005

Physician-to-Physician Phone Line
866-862-3627 (866-UMC-DOCS)

Featured

Related services

- Behavioral Health
- CAY Map and Directions
- CAY Referral & Consultation Request
- CAY Registration Form
- CAY Welcome Packet
- Child Development
- Hearing (Audiology)

More to know

- Mood Disorders
- Anxiety Disorders
- Eating Disorders
- Developmental Disorders
- Mental Health Evaluation
- General Principles of Discipline
- Relationship Development
- Help Your Children Chill Out
- The Trouble with Bullies
- Lying and Stealing
- Time-Out
- Temper Tantrums

More resources

- American Academy of Child & Adolescent Psychiatry
- American Psychological Association
- Children & Adults with Attention Deficit Disorder

QUALITY MEASURE:
FOLLOW-UP FOR CHILDREN STARTING ADHD MEDICATIONS

BACKGROUND

Together, Medicaid and the Children's Health Insurance Program (CHIP) served more than 45 million children in the United States during federal fiscal year (FFY) 2013, representing more than 1 in 3 children in the United States. The majority (66 percent) of children covered by Medicaid and CHIP obtain care from managed care arrangements, although the range of services and the population groups included in these plans vary across states. Because of the varying arrangements, CMS has a diverse set of quality measurement and improvement efforts under way across payment and service delivery settings.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established the Pediatric Quality Measures Program (PQMP), an initiative funded by the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) to support the development of new quality measures for use in the Medicaid and CHIP. With the adoption of a core set of children's health care quality measures in 2010 (referred to as the Child Core Set), CMS had a new set of tools to promote high quality care in Medicaid and CHIP. Over the past four years, CMS has continued development of the measure set and has worked closely with states to break new ground with standardized reporting on CMS's Child Core Set.

One measure in the current Child Core Set is "Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication." Attention deficit/hyperactivity disorder (ADHD) is one of the more common chronic conditions of childhood. Children with ADHD may experience significant functional problems, such as school difficulties; academic underachievement; troublesome relationships with family members and peers; and behavioral problems[1]. Given the high prevalence of ADHD among school-aged children (4 to 12 percent), primary care clinicians will regularly encounter children with ADHD and should have a strategy for diagnosing and long-term management of this condition[2].

Practitioners can convey the efficacy of pharmacotherapy to their patients. AAP guidelines[2] recommend that once a child is stable, an office visit every three to six months allows assessment of learning and behavior. Follow-up appointments should be made at least monthly until the child's symptoms have been stabilized.

[1] American Academy of Pediatrics. Clinical practice guideline: diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. Pediatrics. 2000 May;105(5):1158-70.

[2] American Academy of Pediatrics. Clinical practice guideline: treatment of the school-aged child with attention-deficit/hyperactivity disorder. Pediatrics. 2001 Oct;108(4):1033-44.

METHODS

A retrospective analysis was conducted using Mississippi Medicaid medical claims, pharmacy claims and beneficiary eligibility data for the time period July 2013 through December 2013. Both fee-for-service (FFS) and managed care claims are used for the analysis. The calendar year 2013 was used as the observation year for measurement of performance on this quality measure. The measure is the percentage of children initiating treatment with a stimulant for ADHD who had a follow-up visit with within 30 days of starting therapy.

Denominator: Inclusion criteria determining the beneficiaries in the denominator for the measure were:

- continuously enrolled for 180 days prior and 30 days post prescription start index date (PSID),
- age < 21 at time of PSID, and
- PSID occurred during observation year.

Numerator: Beneficiaries were considered to have received follow-up if a claim for an office visit occurred within 1 to 30 days after the PSID.

This measure is reported as a percentage where a higher score is better. The goal would be a score close to 100%.

RESULTS

As shown in Table 1, a total of 6,354 children met the inclusion criteria and 3,769 (59.3%) had a follow-up visit within 30 days. The performance rates varied significantly across the three DOM pharmacy plans. The majority of beneficiaries were covered by the FFS plan, which had a performance rate of 60.1% of new starts receiving follow-up visits. The two coordinated care plans were significantly lower but similar to each other on performance (Magnolia 51.4% and UHC 52.6%).

TABLE 1: Percent of Children Starting ADHD Medictaion Receiving Follow-up Within 30 Days By Plan

Plan	Total	Follow-Up	
Total	**6,357**	**3,772**	**59.3%**
Fee-for-service	5,760	3,462	60.1%
Magnolia	329	169	51.4%
United Health Care	268	141	52.6%

Significant (p<0.01)

Table 2 shows the breakdown in performance by the type of prescriber. Prescribers were primary care physicians (PCPs) for 49.5% of patients, psychiatrists for 23.2%, and other types of prescribers 27.3% of the time. Performance significantly varied by type of prescriber. PCPs had the lowest rate of follow-up visits; 51.0% compared to 55.6% for psychiatrists and 54.1% for other prescribers.

TABLE 2: Percent of Children Starting ADHD Medication Receiving Follow-up Within 30 Days By Prescriber Type

Plan	Total	Follow-Up	
PCPs	3,005	1.66	55.2%
PSYCHs	1,409	880	62.5%
Other	1,661	1,060	63.8%

Significant (p<0.001)

There was considerable variability in rates for MDs in each provider type (Table 3). More than half of the PCPs and Other prescribers had performance ratings at the extremes; either 0% or 100%. PSYCHs were somewhat less extreme, but still had 40% of prescribers at the extremes. These distributions indicate that education is needed among a fairly large percentage of all types of prescribers.

TABLE 3: Distribution of Prescribers on Percent of Children Starting ADHD Medication and Receiving Follow-up Within 30 Days by Prescriber Type

% of New Starts Receiving Follow-up	% of Prescribers		
	PCPs (n = 462)	PSYCHs (n = 96)	Other (n = 249)
0%	25.8%	17.7%	24.9%
1 - 20%	0.6%	3.0%	2.0%
90 - 99%	4.6%	5.1%	4.3%
100%	23.8%	21.9%	26.9%

Significant differences also were found on rates of follow-up visits by age of the beneficiary (Table 4). Younger children (12 and under) were the most likely to have follow-up visits occur.

TABLE 4: Percent of Children Starting ADHD Medication Receiving Follow-up Within 30 Days By Beneficiary Age

Beneficiary Age	Total	Follow-Up	
<6	671	422	62.9%
6 - 12	4,380	2,651	60.5%
13 - 17	981	512	52.2%
18 - 21	325	187	57.5%

Significant (p<0.001)

As shown in Table 5, considerable variations exists among beneficiaries living in different counties. Simpson county had the highest performance rate (80.3%) compared to the lowest county with at least 10 new starts, Franklin county (29.4%). The variation among counties can be attributed to the lack of specialists in some counties and the extreme variation found within each prescriber type.

TABLE 5: Percent of Children Starting ADHD Medication Receiving Follow-up Within 30 Days By County							
County	Total	Follow-Up In 30 Days		County	Total	Follow-Up In 30 Days	
Adams County	104	51	49.0%	Leflore County	70	42	60.0%
Alcorn County	88	56	63.6%	Lincoln County	89	56	62.9%
Amite County	35	19	54.3%	Lowndes County	113	60	53.1%
Attala County	50	32	64.0%	Madison County	106	69	65.1%
Benton County	24	19	79.2%	Marion County	69	52	75.4%
Bolivar County	61	39	63.9%	Marshall County	84	52	61.9%
Calhoun County	22	15	68.2%	Monroe County	73	49	67.1%
Carroll County	16	6	37.5%	Montgomery County	33	20	60.6%
Chickasaw County	49	17	34.7%	Neshoba County	70	43	61.4%
Choctaw County	26	11	42.3%	Newton County	44	22	50.0%
Claiborne County	8	6	75.0%	Noxubee County	24	11	45.8%
Clarke County	42	23	54.8%	Oktibbeha County	73	41	56.2%
Clay County	64	27	42.2%	Panola County	87	48	55.2%
Coahoma County	61	36	59.0%	Pearl River County	161	103	64.0%
Copiah County	65	44	67.7%	Perry County	23	17	73.9%
Covington County	50	29	58.0%	Pike County	78	39	50.0%
DeSoto County	194	109	56.2%	Pontotoc County	55	32	58.2%
Forrest County	170	108	63.5%	Prentiss County	63	31	49.2%
Franklin County	17	5	29.4%	Quitman County	15	9	60.0%
George County	64	49	76.6%	Rankin County	211	135	64.0%
Greene County	23	13	56.5%	Scott County	66	34	51.5%
Grenada County	58	25	43.1%	Sharkey County	7	4	57.1%
Hancock County	112	65	58.0%	Simpson County	76	61	80.3%
Harrison County	462	250	54.1%	Smith County	30	20	66.7%
Hinds County	450	290	64.4%	Stone County	52	31	59.6%
Holmes County	51	33	64.7%	Sunflower County	72	43	59.7%
Humphreys County	45	28	62.2%	Tallahatchie County	24	17	70.8%
Issaquena County	1	0	0.0%	Tate County	83	43	51.8%
Itawamba County	32	24	75.0%	Tippah County	60	39	65.0%
Jackson County	274	147	53.7%	Tishomingo County	44	31	70.5%
Jasper County	40	23	57.5%	Tunica County	24	13	54.2%
Jefferson County	27	19	70.4%	Union County	75	46	61.3%
Jefferson Davis County	26	16	61.5%	Walthall County	53	31	58.5%
Jones County	175	114	65.1%	Warren County	139	88	63.3%
Kemper County	12	7	58.3%	Washington County	83	42	50.6%
Lafayette County	39	24	61.5%	Wayne County	45	29	64.4%
Lamar County	66	47	71.2%	Webster County	13	9	69.2%
Lauderdale County	177	92	52.0%	Wilkinson County	36	27	75.0%
Lawrence County	27	15	55.6%	Winston County	42	26	61.9%
Leake County	42	22	52.4%	Yalobusha County	28	18	64.3%
Lee County	160	87	54.4%	Yazoo County	78	51	65.4%

CONCLUSION

The Mississippi rate of 59% follow-up is above the national average of 46% reported in the 2014 CMS Annual report on child quality measurement for FFY 2013. However, a rate of 59% is far from ideal. Although as a group PCPs had the lowest rate, all provider types had considerable variation in performance among prescribers. Improvement on this measure is needed and can most effectively be achieved through targeted educational interventions.

Recommendation:

MS-DUR recommends the following actions be undertaken in order to achieve improvement in the percentage of children starting ADHD medications and receiving follow-up within the first 30 days of therapy.

1. MS-DUR should prepare an educational article about the importance of this CMS quality measure that will be submitted to appropriate state medical journal(s).

2. MS-DUR should identify the prescribers performing poorly on this measure and mail them information about the importance of children receiving follow-up visits, as well as information about the services available from the UMMC Center for the Advancement of Children to assist community practitioners in diagnosing and developing treatment plans for children with mental health problems.

3. United Health Care and Magnolia should be encouraged to undertake a similar educational intervention program aimed at improving performance on this CMS Child Core Set quality measure.

ANTIPSYCHOTIC QUALITY MEASURES:
USE OF MULTIPLE ANTIPSYCHOTICS IN CHILDREN

Prepared by University of Mississippi MS-DUR
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BACKGROUND

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established the Pediatric Quality Measures Program (PQMP), an initiative funded by the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) to support the development of new measures in child health care. The CHIPRA PQMP established seven Centers of Excellence working to increase the portfolio of measures that can be used by states, consumers, and policymakers to understand and improve the quality of health care for children in Medicaid and CHIP.

Antipsychotic medication use is an area of interest for measures development given their increased use in children and adolescents and potentially harmful health effects. Although there is little empirical evidence to support its use, the use of multiple concurrent antipsychotics is becoming an increasingly frequent practice in the mental health treatment of youth. One study of a large state Medicaid fee-for-service program found that 7% of children age 6-17 on any antipsychotic were prescribed two or more antipsychotics for longer than 60 days.[1] In another study, 4.1% of youth under age 18 in the New York State Medicaid program who taking an antipsychotic were determined to be on two or more antipsychotics for longer than 90 days. Risks of multiple concurrent antipsychotics in comparison to monotherapy have not been systematically investigated; existing evidence appears largely in case reports, and includes increased risk of serious drug interactions, delirium, serious behavioral changes, cardiac arrhythmias, and death.[2]

In 2013, the CHIRPA National Collaborative for Innovation in Quality Measurement (NCINQ) proposed a quality measure of concurrent use of multiple two or more antipsychotics among children for use in Medicaid and CHIP programs. Although there is no evidence about the safety of using two or more antipsychotics in children, there is some clinical support for the practice. Some children are treated with two antipsychotics; one during the day and a different one at night that has a sedating side effect. No clinical support could be found for the concurrent use of three or more antipsychotics; therefore, the Pharmacy Quality Alliance (PQA) has been working on a similar quality measure using the concurrent use of three or more antipsychotics.

[1] Constantine RJ, Boaz T, Tandon R. (2010). Antipsychotic polypharmacy in the treatment of children and adolescents in the fee-for- service component of a large state Medicaid program. Clinical therapeutics, 32, 949-959.

[2] Safer, D.J., J.M. Zito, and S. DosReis, Concomitant psychotropic medication for youths. Am J Psychiatry, 2003. 160(3): p. 438-49.

METHODS

A retrospective analysis was conducted using Mississippi Medicaid medical and pharmacy claims data and beneficiary eligibility data for July 2013 through June 2014. Both fee-for-service (FFS) and managed care claims are used for the analysis. MS-DUR used the measure specifications provided by NCINQ in their April 2013 call for public feedback on proposed measures and the draft measures being considered by the PQA. These measure address the percentage of children 0 to 20 years of age on any antipsychotic who concomitantly were on multiple antipsychotics for 90 or more days. For this measure lower numbers are better.

Denominator: The denominator contains beneficiaries between ages 0 and 20 as of June 30 2014, who were continuously enrolled for at least 3 months and were taking any antipsychotic medication for at least 90 days during the observation period.

NCINQ Numerator: Children concurrently on two or more antipsychotics for at least 90 days during the observation period. *(NOTE: NCINQ specifications are for 90 consecutive concurrent days. MS-DUR analysis was cumulative 90 days)*

PQA Numerator: Children concurrently on three or more antipsychotics for at least 90 days during the observation period.

RESULTS

As shown in Table 1, a total of 4,435 children and adolescents (age 20 or less) took an antipsychotic for at least 90 days during the observation year. Approximately 68% of these beneficiaries were in the FFS program during the observation year. Overall 464 (10.5%) of these beneficiaries had 90+ days of concurrent therapy on 2 or more antipsychotics and 159 (3.6%) had concurrent therapy on 3 or more antipsychotics.

The rates for these measures were significantly higher in the FFS plan than in the two coordinated care plans. This may reflect a difference in the populations included in the plans or may reflect tighter controls already exist in the coordinated care plans.

TABLE 1: Percentage of Children Taking Antipsychotics Being Treated With Multiple Antipsychotics by Age and Pharmacy Plan (July 2013 - June 2014)					
	Age (As of 6/30/2014)	Pharmacy Plan			
		FFS	Magnolia	United Health Care	Total
Beneficiaries taking at least 1 AP for longer than 90 days (denominator)	0-5	61	19	10	90
	6-11	1,138	244	173	1,555
	12-17	1,584	381	248	2,213
	18-20	238	185	154	577
	TOTAL	3,021	829	585	4,435
Beneficiaries taking multiple (2 or more) concurrent APs for longer than 90 days (numerator)	0-5	3 4.9%	0 0.0%	0 0.0%	3 3.3%
	6-11	58 5.1%	16 6.6%	8 4.6%	82 5.3%
	12-17	216 13.6%	39 10.2%	23 9.3%	278 12.6%
	18-20	60 25.2%	25 13.5%	16 10.4%	101 17.5%
	TOTAL	337 11.2%	80 9.7%	47 8.0%	464 10.5%
Beneficiaries taking multiple (3 or more) concurrent APs for longer than 90 days (numerator)	0-5	0 0.0%	0 0.0%	0 0.0%	0 0.0%
	6-11	17 1.5%	3 1.2%	2 1.2%	22 1.4%
	12-17	76 4.8%	12 3.1%	2 0.8%	90 4.1%
	18-20	33 13.9%	8 4.3%	6 3.9%	47 8.1%
	TOTAL	126 4.2%	23 2.8%	10 1.7%	159 3.6%

In the NCINQ call for comments, they presented preliminary results for the proposed quality measures based on performance for 11 states using the Medicaid Analytic Extract files from 2008. Their preliminary results for the two or more concomitant antipsychotics measure are reported in Table 2. It is important to note that the NCINQ specifications are for 90+ **consecutive** concurrent days and the MS-DUR analysis was a cumulative total of 90+ days. MS-DUR used the less restrictive criteria in order to test a more manageable clinical edit criteria for use in electronic or manual prior authorization. Rates would be expected to be somewhat lower with the more restrictive NCINQ specifications. Compared to the more restrictive rates provided by NCINQ, it appears that the Mississippi Medicaid program may be on the high side for performance on this measure.

Table 2: Preliminary Results From NCINQ Analysis of 11 State Medicaid Programs (2008 data)							
	Overall	Distribution Across 11 States					
Measure	Performance	Minimum	25th Percentile	Median	Mean	75th Percentile	Maximum
2 + APS for 90+ consecutive concurrent days	6.6%	2.9%	3.7%	6.6%	6.0%	7.7%	9.4%

CONCLUSION

Although Mississippi Medicaid performs fairly well on quality measures for the overall percentage of children taking antipsychotics, it appears that performance is not as good at controlling polypharmacy with antipsychotics. There is considerable debate about what rate is appropriate for concurrent use of 2 or more antipsychotics since there are sound clinical reasons for using 2 or more different products. However, there is no clinical support for concurrent use of 3 or more antipsychotics. Although the percentage of children concurrently taking 3 or more antipsychotics is small, possible drug utilization management actions are needed to further reduce this occurrence.

Recommendation:

MS-DUR recommends the following actions be undertaken in order to reduce the percentage of children being treated concomitantly with three or more antipsychotics.

1. An electronic clinical edit should be implemented that would force manual prior authorization for any claim that results in concurrent use of 3 or more antipsychotics.

2. Manual review criteria should be developed requiring that concurrent use of 3 or more antipsychotics can only occur when prescribed by a psychiatrist or recommended by a psychiatric consult.

SYNAGIS UTILIZATION UPDATE – 2014-15 SEASON

BACKGROUND

Palivizumab was licensed in June 1998 by the Food and Drug Administration for the reduction of serious lower respiratory tract infection caused by respiratory syncytial virus (RSV) in children at increased risk of severe disease. The Mississippi Division of Medicaid (DOM) supports the administration of Synagis® for children meeting the American Academy of Pediatrics (AAP) criteria for RSV immunoprophylaxis. On July 28, 2014, the AAP published their latest policy statement, "Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection" on-line in *Pediatrics*[1]. At the August 2014 DUR Board Meeting the new guidelines the board voted to adopt the new guidelines as the criteria to be used by DOM for the 2014-15 Season.

PALIZUMAB UTILIZATION

Table 1 shows the total dollars paid for Synagis treatment by annual season and month and the percentage change during the 2014-15 season compared to the same month in the 2013-14 season. Overall, there has been a 48% decrease in expenditures this year. This is in line with the projected decrease in the number of patients treated due to the more restrictive treatment guidelines adopted for this season. The decrease in payments has varied somewhat by plan. The overall change in dollars paid for Synagis treatment so far this season for FFS is -43% compared to -41% for Magnolia and -59% for United Health Care.

TABLE 1: Total Dollars Paid By Season and Month

Plan	Month	2012-13	2013-14	2014-15	Change 2013-14 to 2014-15
Total	October	$631,705	$276,265	$203,566	-26.3%
	November	$507,819	$955,354	$432,392	-54.7%
	December	$1,031,228	$1,150,556	$598,613	-48.0%
FFS	October	$494,537	$78,878	$50,556	-35.9%
	November	$396,751	$165,411	$89,116	-46.1%
	December	$394,775	$211,316	$121,090	-42.7%
Magnolia	October	$69,748	$174,957	$145,019	-17.1%
	November	$59,995	$331,831	$123,136	-62.9%
	December	$359,676	$473,603	$314,627	-33.6%
UHC	October	$51,257	$19,818	$5,380	-72.9%
	November	$49,787	$455,501	$218,755	-52.0%
	December	$263,470	$461,660	$162,896	-64.7%

[1] American Academy of Pediatric Committee on Infectious Diseases and Bronchiolitis Guidelines Committee. Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. *Pediatrics.* Available at http://pediatrics.aappublicaions.org/content/early/2014/07/23/peds.2014-1665.

Table 2 shows the number of beneficiaries receiving Synagis treatment by annual season and month and the percentage change during the 2014-15 season compared to the same month in the 2013-14 season. Overall, there has been a 48% decrease in the number of beneficiaries treated. Again, this is in line with the projected decrease due to the more restrictive treatment guidelines adopted for this season. The decrease in beneficiaries also varied by plan. The overall the change in the number of beneficiaries treated so far this season for FFS is -47% compared to -44% for Magnolia and -53% for United Health Care.

TABLE 2: Number of Beneficiaries By Season and Month

Plan	Month	2012-13	2013-14	2014-15	Change 2013-14 to 2014-15
Total	October	246	95	75	-21.1%
	November	207	346	161	-53.5%
	December	362	387	192	-50.4%
FFS	October	198	26	20	-23.1%
	November	172	75	35	-53.3%
	December	131	78	39	-50.0%
Magnolia	October	25	60	51	-15.0%
	November	21	117	43	-63.2%
	December	129	159	93	-41.5%
UHC	October	17	8	3	-62.5%
	November	13	153	82	-46.4%
	December	96	147	60	-59.2%

Table 3 shows the average dollars paid per beneficiary receiving Synagis treatment by annual season and month and the percentage change during the 2014-15 season compared to the same month in the 2013-14 season. The average cost per beneficiary was expected to be fairly constant based on the new guidelines resulting in younger/smaller infants being treated with lower doses that would offset price increases. Overall, the average payment per beneficiary treated increased only 0.3%. Again, this varied by plan. The overall change in payments/beneficiary treated so far this season for FFS is +9.0% compared to +6.8% for Magnolia and -12.3% for United Health Care.

TABLE 3: Dollars Paid/Beneficiary By Season and Month

Plan	Month	2012-13	2013-14	2014-15	Change 2013-14 to 2014-15
Total	October	$2,567.91	$2,908.05	$2,714.21	-6.7%
	November	$2,453.23	$2,761.14	$2,685.66	-2.7%
	December	$2,848.70	$2,973.01	$3,117.78	4.9%
FFS	October	$2,497.66	$3,033.78	$2,527.78	-16.7%
	November	$2,306.69	$2,205.48	$2,546.18	15.4%
	December	$3,013.55	$2,709.18	$3,104.88	14.6%
Magnolia	October	$2,789.93	$2,915.95	$2,843.52	-2.5%
	November	$2,856.89	$2,836.16	$2,863.62	1.0%
	December	$2,788.19	$2,978.64	$3,383.09	13.6%
UHC	October	$3,015.15	$2,477.31	$1,793.27	-27.6%
	November	$3,829.77	$2,977.13	$2,667.75	-10.4%
	December	$2,744.48	$3,140.54	$2,714.93	-13.6%

Overall, the changes in utilization and cost for Synagis this season is in line with expectations based on the change in the treatment guidelines. However, the significant differences between the two coordinated care plans call for further analysis with respect to how the new guidelines were implemented. This will be addressed when MS-DUR provides the board a more detailed analysis of this Synagis season at the May DUR Board Meeting.

NO ACTION NEEDED: This is a report to the DUR Board on utilization trends in the three pharmacy plans for information and discussion purposes only. No action is being sought at this time.

HEPATITIS C TREATMENT UPDATE

In the last two years, four new Hepatitis C treatments have been introduced that have significantly changed treatment expectations and costs for a course of treatment. The Division of Medicaid (DOM) has developed new prior authorization criteria several times as these new products have entered the market. The current DOM PDL is shown below.

Viekira Pak (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets) was recently introduced to the market but has not yet been reviewed by the DOM P&T Committee. Due to the high cost of the new treatment options, utilization is being closely monitored.

Hepatitis C Treatments by Pharmacy Plan and Month

Month		Fee-For-Service Product					Magnolia Product					United Health Care Product				
		HAR	OLY	SOV	VIC	Total	HAR	OLY	SOV	VIC	Total	HAR	OLY	SOV	VIC	Total
2014	Jan	0	0	1	0	1	0	0	0	2	2	0	0	3	0	3
	Feb	0	1	2	0	3	0	0	4	4	8	0	0	6	0	6
	Mar	0	0	1	0	1	0	0	3	2	5	0	1	9	0	10
	Apr	0	3	5	0	8	0	0	6	2	8	0	1	13	0	14
	May	0	4	7	0	11	0	0	7	0	7	0	1	8	0	9
	Jun	0	3	8	0	11	0	0	25	1	26	0	3	9	0	12
	Jul	0	1	4	0	5	0	0	16	0	16	0	2	7	0	9
	Aug	0	0	5	0	5	0	0	14	0	14	0	3	9	0	12
	Sep	0	1	7	0	8	0	0	14	0	14	0	1	5	0	6
	Oct	0	4	11	0	15	1	0	15	0	16	0	1	4	0	5
	Nov	0	1	8	0	9	2	1	7	0	10	0	0	2	0	2
	Dec	3	1	7	0	11	6	0	9	0	15	0	3	5	0	8
2015	Jan	1	0	2	0	3	0	0	0	0	0	0	0	0	0	0
Total		4	19	68	0	91	9	1	120	11	141	0	16	80	0	96

HAR = Harvoni; OLY = Olysio; SOV = Sovaldi; VIC = Victrilis

NO ACTION NEEDED: This is a report to the DUR Board on utilization trends in the three pharmacy plans for information and discussion purposes only. No action is being sought at this time.

Detail Resource Utilization Report - Top 25 Drugs by Dollars Paid Last Month

Generic Molecule	Sep 2014 $ Paid	Oct 2014 $ Paid	Nov 2014 $ Paid	Sep 2014 # Claims	Oct 2014 # Claims	Nov 2014 # Claims	Sep 2014 # Benes	Oct 2014 # Benes	Nov 2014 # Benes
Montelukast	$1,604,565	$1,546,722	$1,534,633	8,162	8,146	7,930	8,039	7,967	7,849
-------Singulair	$1,603,919	$1,500,013	$1,508,745	8,157	7,716	7,684	8,034	7,562	7,612
-------Montelukast Sodium	$646	$46,709	$25,888	5	430	246	5	421	241
Lisdexamfetamine	$1,243,032	$1,337,982	$1,164,827	5,953	6,411	5,573	5,713	6,073	5,421
-------Vyvanse	$1,243,032	$1,337,982	$1,164,827	5,953	6,411	5,573	5,713	6,073	5,421
Methylphenidate	$785,270	$835,167	$736,549	4,701	4,917	4,350	4,305	4,455	4,021
-------Methylphenidate Hydrochloride Er	$484,837	$475,613	$422,405	2,925	2,887	2,558	2,781	2,702	2,447
-------Quillivant Xr	$126,825	$157,927	$143,242	523	636	586	506	613	580
-------Metadate Cd	$95,094	$124,331	$103,757	405	542	439	385	511	427
-------Daytrana	$56,624	$54,829	$47,611	234	228	196	231	223	192
-------Methylphenidate Hydrochloride	$9,674	$9,829	$8,911	567	572	527	534	534	498
-------Methylin	$6,447	$8,465	$8,832	16	24	23	16	23	23
-------Methylphenidate Hydrochloride Sr	$619	$601	$630	11	11	12	11	11	12
-------Ritalin La	$1,199	$1,195	$595	6	6	3	4	4	3
Aripiprazole	$723,483	$813,105	$717,807	1,141	1,260	1,109	1,049	1,137	1,046
-------Abilify	$716,465	$801,698	$700,866	1,134	1,251	1,097	1,043	1,133	1,037
-------Abilify Maintena	$1,628	$6,510	$13,023	1	4	8	1	3	7
-------Abilify Discmelt	$5,390	$4,898	$3,918	6	5	4	6	4	4
Budesonide	$650,433	$716,979	$701,628	1,474	1,634	1,577	1,448	1,609	1,547
-------Pulmicort Respules	$630,516	$701,570	$686,961	1,382	1,544	1,499	1,360	1,523	1,474
-------Pulmicort Flexhaler	$13,851	$13,741	$11,647	87	88	74	86	87	74

Only drugs with > $500 paid (amount reimbursed to pharmacy) in last month are included in detail listing

Detail Resource Utilization Report - Top 25 Drugs by Dollars Paid Last Month

Generic Molecule	Sep 2014 $ Paid	Oct 2014 $ Paid	Nov 2014 $ Paid	Sep 2014 # Claims	Oct 2014 # Claims	Nov 2014 # Claims	Sep 2014 # Benes	Oct 2014 # Benes	Nov 2014 # Benes
-------Budesonide	$4,748	$1,667	$3,020	4	2	4	4	2	4
Amphetamine-Dextroamphetamine	$658,219	$680,648	$612,227	4,121	4,287	3,840	3,513	3,647	3,340
-------Adderall Xr	$552,691	$568,752	$510,855	2,351	2,419	2,172	2,204	2,267	2,074
-------Amphetamine-Dextroamphetamine	$104,762	$111,896	$100,575	1,766	1,868	1,665	1,624	1,711	1,569
-------Adderall	$766	$0	$797	4	0	3	4	0	3
Oseltamivir	$46,163	$115,832	$599,221	272	650	3,219	267	647	3,215
-------Tamiflu	$46,163	$115,832	$599,221	272	650	3,219	267	647	3,215
Guanfacine	$573,907	$595,971	$527,353	3,400	3,510	3,187	3,213	3,314	3,068
-------Intuniv	$550,116	$571,140	$504,220	1,825	1,884	1,672	1,743	1,773	1,622
-------Guanfacine Hydrochloride	$23,791	$24,831	$23,133	1,575	1,626	1,515	1,481	1,551	1,461
Mometasone Nasal	$587,490	$574,751	$499,427	3,197	3,134	2,725	3,176	3,107	2,714
-------Nasonex	$587,490	$574,751	$499,427	3,197	3,134	2,725	3,176	3,107	2,714
Albuterol	$496,094	$512,909	$478,711	10,445	11,203	10,714	9,090	9,701	9,457
-------Albuterol Sulfate	$160,097	$177,894	$172,456	5,043	5,693	5,664	4,888	5,508	5,515
-------Proventil Hfa	$191,463	$182,631	$155,556	2,752	2,654	2,235	2,689	2,584	2,201
-------Ventolin Hfa	$89,994	$95,761	$95,256	1,702	1,849	1,830	1,680	1,810	1,800
-------Proair Hfa	$54,209	$56,144	$55,272	935	985	973	918	967	964
Dexmethylphenidate	$480,916	$516,115	$456,493	2,405	2,579	2,279	2,033	2,156	1,969
-------Focalin Xr	$461,127	$495,128	$436,464	1,929	2,070	1,821	1,838	1,946	1,758
-------Dexmethylphenidate Hydrochloride	$17,521	$18,884	$18,088	432	468	427	414	442	415
-------Focalin	$2,269	$2,102	$1,941	44	41	31	44	40	30

Only drugs with > $500 paid (amount reimbursed to pharmacy) in last month are included in detail listing

Detail Resource Utilization Report - Top 25 Drugs by Dollars Paid Last Month

Generic Molecule	Sep 2014 $ Paid	Oct 2014 $ Paid	Nov 2014 $ Paid	Sep 2014 # Claims	Oct 2014 # Claims	Nov 2014 # Claims	Sep 2014 # Benes	Oct 2014 # Benes	Nov 2014 # Benes
Quetiapine	$465,681	$476,479	$452,381	1,089	1,085	1,011	891	890	851
-------Seroquel	$382,708	$383,888	$364,327	943	933	867	762	764	720
-------Seroquel Xr	$80,508	$90,956	$86,514	142	149	142	130	128	135
-------Quetiapine Fumarate	$2,466	$1,635	$1,540	4	3	2	4	3	2
Azithromycin	$286,647	$328,055	$366,075	8,706	9,779	10,980	8,555	9,593	10,789
-------Azithromycin	$243,411	$285,251	$318,257	6,843	7,935	8,922	6,723	7,781	8,772
-------Azithromycin 5 Day Dose Pack	$41,053	$40,167	$44,960	1,776	1,743	1,946	1,761	1,728	1,929
-------Azithromycin 3 Day Dose Pack	$2,184	$2,636	$2,858	87	101	112	86	101	110
Amoxicillin-Clavulanate	$305,555	$341,852	$351,695	4,878	5,234	5,413	4,795	5,156	5,341
-------Amoxicillin-Clavulanate	$299,343	$326,014	$340,223	4,870	5,218	5,398	4,787	5,142	5,327
-------Augmentin	$4,506	$14,422	$10,049	6	15	13	6	15	13
-------Augmentin Xr	$1,706	$1,416	$1,423	2	1	2	2	1	2
Somatropin	$480,160	$467,922	$340,738	126	126	98	123	115	98
-------Norditropin Flexpro Pen	$119,767	$103,595	$92,768	38	34	32	37	34	32
-------Genotropin	$122,420	$124,849	$67,070	21	24	14	19	21	14
-------Nutropin Aq Nuspin 20	$97,216	$96,019	$60,247	20	20	12	20	18	12
-------Nutropin Aq Nuspin 10	$72,726	$67,306	$56,011	25	23	21	25	23	21
-------Genotropin Miniquick	$42,895	$47,246	$39,005	12	13	10	12	11	10
-------Saizen	$11,340	$11,340	$11,340	1	1	1	1	1	1
-------Nutropin Aq Pen 20 Cartridge	$5,648	$5,648	$5,648	1	1	1	1	1	1
-------Nutropin Aq Pen 10 Cartridge	$3,770	$7,541	$3,770	2	4	2	2	2	2

Only drugs with > $500 paid (amount reimbursed to pharmacy) in last month are included in detail listing

Detail Resource Utilization Report - Top 25 Drugs by Dollars Paid Last Month

Generic Molecule	Sep 2014 $ Paid	Oct 2014 $ Paid	Nov 2014 $ Paid	Sep 2014 # Claims	Oct 2014 # Claims	Nov 2014 # Claims	Sep 2014 # Benes	Oct 2014 # Benes	Nov 2014 # Benes
-------Omnitrope Pen 5 Cartridge	$304	$304	$2,690	2	2	2	2	2	2
-------Nutropin Aq Nuspin 5	$3,770	$3,770	$1,885	2	2	1	2	2	1
Cefdinir	$237,899	$268,519	$291,584	2,905	3,265	3,471	2,856	3,219	3,428
-------Cefdinir	$237,899	$268,519	$291,584	2,905	3,265	3,471	2,856	3,219	3,428
Ondansetron	$241,003	$283,946	$271,814	2,432	2,711	2,624	2,377	2,641	2,560
-------Ondansetron Hydrochloride	$240,558	$283,068	$271,814	2,431	2,709	2,624	2,376	2,639	2,560
Anti-Inhibitor Coagulant Complex	$572,514	$442,373	$268,534	4	3	2	3	2	2
-------Feiba Nf	$572,514	$442,373	$268,534	4	3	2	3	2	2
Cetirizine	$266,869	$281,961	$252,418	14,473	15,258	13,576	14,238	15,004	13,457
-------Cetirizine Hydrochloride	$264,442	$279,385	$250,417	14,168	14,948	13,340	13,936	14,700	13,221
-------All Day Allergy	$1,774	$1,912	$1,478	252	252	198	250	248	198
-------All Day Allergy Children's	$653	$665	$523	53	58	38	53	58	38
Sofosbuvir	$206,982	$325,258	$236,551	7	11	8	7	10	8
-------Sovaldi	$206,982	$325,258	$236,551	7	11	8	7	10	8
Fluticasone-Salmeterol	$238,118	$250,402	$234,105	826	863	815	814	838	801
-------Advair Diskus	$193,676	$201,184	$195,605	686	713	694	676	694	685
-------Advair Hfa	$44,442	$49,219	$38,500	140	150	121	138	147	119
Antihemophilic Factor	$722,674	$838,740	$229,737	51	49	21	33	29	14
-------Recombinate	$141,511	$141,955	$115,291	11	11	10	6	5	5
-------Advate Rahf-Pfm	$480,871	$631,988	$108,451	34	35	9	23	22	8
-------Helixate Fs	$31,373	$5,995	$5,995	3	2	2	2	1	1

Only drugs with > $500 paid (amount reimbursed to pharmacy) in last month are included in detail listing

Detail Resource Utilization Report - Top 25 Drugs by Dollars Paid Last Month

Generic Molecule	Sep 2014 $ Paid	Oct 2014 $ Paid	Nov 2014 $ Paid	Sep 2014 # Claims	Oct 2014 # Claims	Nov 2014 # Claims	Sep 2014 # Benes	Oct 2014 # Benes	Nov 2014 # Benes
Olanzapine	$214,072	$206,102	$197,937	443	443	409	328	322	317
-------Olanzapine	$213,850	$205,662	$197,711	438	433	404	326	318	315
Insulin Glargine	$200,278	$203,238	$193,604	552	548	513	524	515	495
-------Lantus	$132,384	$136,314	$123,846	380	391	346	361	362	331
-------Lantus Solostar Pen	$67,894	$66,924	$69,758	172	157	167	167	155	165
Risperidone	$205,388	$209,546	$185,777	2,131	2,130	1,944	1,867	1,874	1,748
-------Risperidone	$198,457	$204,659	$181,915	2,123	2,124	1,940	1,862	1,870	1,744
-------Risperdal Consta	$6,482	$4,437	$3,413	7	5	3	5	4	3

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