

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



MISSISSIPPI DIVISION OF
MEDICAID

**May 7, 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
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, 2017

James R. "Beau" Cox, Pharm.D. **(Co-Chair)**
Tara Pharmacy
110 Metroplex Blvd., Suite H
Pearl, MS 39208
Term Expires: June 30, 2016

Jason Parham, M.D.
UMMC Department of Medicine
2500 North State Street
Jackson, MS 39216
Term Expires: June 30, 2016

Logan Davis, Pharm.D., MBA
Vital Care, Inc.
1170 NE Industrial Park Rd
Meridian, MS 39301
Term Expires: June 30, 2016

Bobby Proctor, M.D.
Laurel Family Clinic
1440 Jefferson St.
Laurel, MS 39440
Term Expires: June 30, 2016

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

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

Antoinette M. Hubble, M.D.
McComb Children's Clinic
300 Rawls Dr. Ste 100
McComb, MS 39648
Term Expires: June 30, 2017

Dennis Smith, R.Ph. **(Chair)**
Polk's Discount Pharmacy
1031 Star Rd
Brandon, MS 39042
Term Expires: June 30, 2017

Sarah Ishee, Pharm.D.
Kroger Pharmacy
2340 Hwy 15 N
Laurel, MS 39440
Term Expires: June 30, 2015

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

2015 DUR Board Meeting Dates

February 5, 2015
August 6, 2015

May 7, 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

May 7, 2015

Welcome	Dennis Smith, R.Ph. (Chair)
Old Business	Dennis Smith, R.Ph. (Chair)
Approval of February 2015 Meeting Minutes	page 5
Update on Metabolic Monitoring for Children Taking Antipsychotics	page 11
Update on Follow-up Visits for Children Starting ADHD Medications	page 13
Resource Utilization Review (Hardwick)	
Enrollment Statistics	page 16
Pharmacy Utilization Statistics	page 16
Top 10 Drug by Change in Dollars Paid	page 17
Top 10 Drug by Change in Number of Claims	page 18
Pharmacy Program Update	Judy Clark, R.Ph.
Feedback and Discussion from the Board	
New Business	
<i>Special Analysis Projects</i>	
Clinical Guidelines for Hysingla ER (Hardwick)	page 20
Overview of Uniform Preferred Drug List (UPDL) Monthly Review (Banahan)	page 22
Concomitant Use Naltrexone and Bupropion for Weight Control (Banahan)	page 26
Evaluation of Potential Criteria for Use of Multiple Hypoglycemic Agents (Banahan)	page 28
Overview of Office of Inspector General Report on 2 nd Generation Antipsychotics and Children (Banahan)	page 33
<i>Exceptions Monitoring Criteria Recommendations</i>	page 37
Next Meeting Information	Dennis Smith, R.Ph. (Chair)

DUR Board Meeting Minutes

**MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE February 5, 2015 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	9	3

Dr. McIntosh and Dr. Simmons arrived after the meeting was called to order but were present for all votes taken by the board except for the approval of the minutes from the prior meetings.

Also Present:

DOM Staff:

Judith Clark, R.Ph., DOM Pharmacy Bureau Director; Terri Kirby, R.Ph., DOM Clinical Pharmacist; Kristi Plotner, DOM Policy Planning and Development

MS-DUR Staff:

Ben Banahan, Ph.D., Project Director

Xerox Staff:

Leslie Leon, Pharm.D.

Visitors:

David Elkin, UMMC Center for Advancement of Youth; Bob Firnbey, Gilead; Lee Ann Mayo, Capital Resources ; Phil Hecht, Abbvie; Calistra Goheen, Astra Zeneca; John Kirby, Sanofio; Brian Berhow, Sunovion; Doug Wood, ViiV; Juan Trippe, Reckitt Benckiser Pharmaceuticals; Adriana Sanchez, Supernus Pharmaceuticals.

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

Old Business:

Dr. Hubble made a motion for approval of the minutes from the August 21, 2014 and November 20, 2014 meetings. The motion was seconded by Dr. Cox and approved unanimously.

Special reports from November 2014 meeting needing action
Metabolic Screening for Children on Antipsychotics

Dr. Banahan briefly reviewed the report from the November board meeting. MS-DUR recommendations at the previous meeting were:

1. MS-DUR should prepare an educational article about the importance of metabolic monitoring in children taking antipsychotics for distribution in quarterly electronic mailings.
2. MS-DUR should develop an exception monitoring routine that will identify beneficiaries who have failed to meet the 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.

During discussion, Dr. Undesser pointed out that psychiatrists and other physicians who practice in settings without an in-house lab will only be able to recommend to parents that lab tests be performed at another setting. It was also recommended that the educational information include the procedure codes that would be used to determine if follow up care took place. Dr. Undesser made a motion that the recommendations be approved. It was seconded by Dr. Hubble and passed unanimously.

Use of Opioids at Higher Doses in Persons Without Cancer – Morphine Equivalent Dose Limits

Dr. Banahan briefly reviewed the report from the November board meeting and pointed out that previous board discussions about high dose opioid use were related to methods for DOM to use in identifying potential drug abuse for investigation that would result in lock in. The current report and recommendations are aimed at implementing clinical edits to help prevent addiction by requiring a manual PA for extended use of high doses of narcotics. During the November board meeting the original MS-DUR recommendation was modified by the board to be:

1. DOM should implement an electronic prior authorization clinical edit to prevent beneficiaries from exceeding the morphine equivalent dose of 100mg/day for more than 60 days during the prior year.
2. United Health Care and Magnolia Health Plan should be encouraged to implement a similar edit for Medicaid beneficiaries enrolled in Coordinated Care.

After discussion, a motion to approve the recommendations was made by Dr. Hubble and seconded by Dr. Davis. The motion was approved unanimously.

Contraceptive Products – Documenting Use for Birth Control

Dr. Banahan briefly reviewed the report from the November board meeting and the MS-DUR recommendations:

1. DOM should implement an electronic prior authorization clinical edit for all contraceptives (oral, injectable, or implant) requiring (a) a diagnosis code for counseling and advice on contraceptive management (V25.0x) or a diagnosis for 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 (b) an appropriate 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 Health Plan should be encouraged to implement a similar edit for Medicaid beneficiaries enrolled in Coordinated Care.

During discussion the board recommended that the look back period for diagnosis codes should be set to whatever period of time the Office of Inspector General (OIG) is using in ongoing state audits. A motion to approve the recommendations was made by Dr. Simmons and seconded by Dr. Cox. The motion was approved unanimously.

New Business (CAY):

In deference to the need for Dr. David Elkin to leave for another meeting, the agenda was amended to move his presentation on the UMMC Center for Advancement of Youth (CAY) to the first item on the agenda after old business. Dr. Elkin, the Director of CAY, informed the board about the DOM Children's Collaborative Project which is designed to help children with mental health problems get more rapid diagnosis and establish treatment plans. This program involves a coordinated effort among the UMMC Department of Psychiatry and Behavioral Health, the Mississippi Children's Home Services, and community practitioners throughout the state.

Resource Utilization Review:

Dr. Banahan pointed out that MS-DUR enrollment data shows a decline in the growth in enrollment. Ms. Clark commented that recent internal reports indicate that enrollment is continuing to increase. Dr. Banahan informed the board that no significant resource utilization changes have occurred that need the attention of the board. The most significant changes in products based on number of prescriptions and amount paid were attributed to seasonal allergies, flu season, and the beginning of the Synagis season.

Pharmacy Program Update:

Ms. Clark shared with the board a variety of handouts from recent DOM provider notices. She commented that there are many changes going on in Medicaid at this time and she encouraged all providers to check the DOM website for updates and notices on a regular basis. She reported to the board that several pharmacies are currently being audited to investigate reports of fraudulent billing of generic products using brand NDCs when brands are preferred. Ms. Clark also discussed the recently implemented Universal Preferred Drug List (PDL) and the ongoing efforts to have the fee-for-service and coordinated care plans use the same prior authorization criteria. She pointed out that the Universal PDL will require constant management and adjustments in order to maximize savings for DOM while minimizing confusion and problems for providers.

Feedback and Discussion from the Board

Dr. Banahan informed the board that Ms. Hardwick had suggested an addition to the quarterly agenda where the board could provide feedback or ask questions about any items they felt were of importance to DOM providers. Mr. Smith raised the issue of non-coverage messages to pharmacies not always informing the pharmacy as to which plan a beneficiary was currently enrolled in. It was noted that when a claim is submitted through the FFS Point of Sale (POS) denial of coverage notices inform the provider about which plan (FFS or a coordinated care) the beneficiary is currently enrolled. Denial of coverage notices from the coordinated care plans do not include this information. It was pointed out that the coordinated care plans do not have access to the information needed to provide the additional information. Although it results in an additional transaction charge with the pharmacy switch vendor, pharmacies can submit the claim to FFS and get this information when a rejection has been received. The board also asked that DOM work to establish universal PA forms for use by all plans in order to make it easier when patients move from one plan to another. Board members pointed out that ideally the already approved PA would be able to transfer with the patient now that the Universal PDL is in place.

New Business:

Special Analysis Projects

Follow Up Care for Children Starting ADHD Medications

Dr. Banahan reviewed the MS-DUR analysis of DOM performance on the CMS Medicaid Child Core Set quality measure addressing follow-up care for children starting stimulant therapy for attention deficit/hyperactivity disorder (ADHD). In calendar year 2013, only 59% of children starting ADHD therapy had a follow-up visit documented within 30 days. There was considerable variation in performance among individual physicians and by county. MS-DUR recommendations were:

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.

Board discussion included a recommendation that, for educational intervention purposes, the measure criteria should be adjusted to receiving follow-up care within 45 days and continuing stimulant therapy for greater than 31 days. Dr. Simmons made a motion to approve the recommendations. The motion was seconded by Dr. Bell and approved unanimously.

Antipsychotic Polypharmacy Among Children

Dr. Banahan reviewed the results from the MS-DUR analysis of DOM performance on the quality measure for multiple antipsychotic medication use by children. During the period July 2013 to June 2014, 3.6% of children on antipsychotics took three or more antipsychotics concurrently and 10.5% took two or more antipsychotics concurrently. Mississippi performance on the two or more measure placed the state around the top 25th percentile based on information available from CMS. MS-DUR recommendations were:

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 which requires that concurrent use of 3 or more antipsychotics can only occur when prescribed by a psychiatrist or recommended by a psychiatric consult.

During discussion, Ms. Clark asked that the FFS numbers be rerun to remove children in Psychiatric Residential Treatment Centers (PRTCs) and that the edit not include these children. Dr. Parham moved for acceptance of the recommendations. The motion was seconded by Dr. Undesser and approved unanimously.

Synagis (palivizumab) Use Update

Dr. Banahan presented an analysis of the trends in Synagis use so far this season. It was noted that overall there has been about a 45% reduction in total expenditures for Synagis primarily due to a reduction in the number of children qualifying under the new treatment guidelines. Dr. Davis asked that, if possible, the final analysis of the Synagis season reported at the May meeting include some outcome measures for children getting Synagis and those that would have under the old guidelines, but did not under the new guidelines.

Hepatitis C Treatment Update

Dr. Banahan presented a descriptive analysis of the use of the major Hepatitis C medication by the three prescription plans during the previous year. A more detailed analysis of this therapeutic area will be presented at the May meeting that will allow comparison of treatment under the universal PDL.

Other Business

There was no other business.

Next Meeting Information:

Mr. Smith announced that the next meeting date is May 7, 2015 at 2:00p.m. He thanked everyone for making the effort to attend the DUR Board meeting and having such good discussion. The meeting adjourned at 3:20 pm.

Submitted,
Evidence-Based DUR Initiative, MS-DUR

DRAFT

Old Buisness

UPDATE ON METABOLIC MONITORING FOR CHILDREN TAKING ANTIPSYCHOTICS

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 National Collaborative for Innovation in Quality Measurement (NCINQ) developed a measure - "the percentage of children 0 to 20 years of age on any antipsychotic who had metabolic screening documented during the measurement year". Children on antipsychotics should have both a test for blood glucose and cholesterol during each year. State Medicaid programs are being encouraged to use this measure in utilization review of children taking antipsychotics.

At the February 2015 meeting of the DUR Board, the following recommendations were approved with respect to metabolic monitoring of 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 mailings.
2. MS-DUR should develop an exception monitoring routine that will identify beneficiaries who have failed to meet the 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.

An educational article is currently being written. Programming has been completed for the exceptions monitoring and educational intervention. Each month:

- An analysis will be run evaluating providers' performance on the quality measure
- Providers will be ranked based on the number of their patients who have filled antipsychotic prescriptions during the previous month and have not had appropriate metabolic monitoring documented during the previous year.
- The 100 providers with the greatest number of patients not receiving monitoring will be mailed a letter each month (see attached).
- A provider will only be sent one letter within a four month period of time.

The educational intervention will be continued for at least 6 months. After 6 months, MS-DUR will report on current performance within Medicaid and will make additional recommendations, if needed, to address this important quality-of-care measure. As with other quality-of-care related educational interventions, all children and providers in Medicaid, regardless of pharmacy plan, will be included in this initiative.

DATE
MD_NAME,
MD_ADDRESS
MD_ADDRESS, MS MD_ZIP

Dear Dr.MD_NAME,

The Mississippi Division of Medicaid (DOM) Office of Pharmacy is committed to improving the quality of care provided to Mississippi Medicaid beneficiaries. DOM’s Drug Utilization Review or DUR Board, comprised of twelve physicians and pharmacists from around the state, has recommended several initiatives addressing quality issues regarding the treatment of children with mental health illnesses. This letter is being sent as part of our initiative regarding metabolic monitoring for children taking antipsychotics.

THE GOAL

The American Academy of Child and Adolescent Psychiatry practice parameters recommend careful monitoring of metabolic side effects for children taking antipsychotics. The Centers for Medicare and Medicaid Services (CMS) has proposed the following quality measure for consideration for use in Medicaid programs: *The percentage of beneficiaries below the age of 21 years on antipsychotics who are being monitored for glucose and lipid levels.* A recent analysis found that of the children in Mississippi Medicaid taking antipsychotics, only 30% received a blood glucose test, 14% received a lipid test and 13% received both tests during the measurement year. These results indicate that the Mississippi DOM is currently performing at the 25th percentile for state Medicaid programs on this measure.

YOUR SCORE

Analysis of Medicaid children taking antipsychotics during the previous year showed:

Physician’s name	Total number of patients	Patients who received metabolic screening
MD_NAME	MD_DENOM	Glucose: MD_NUM_GL MD_GL_PER Lipid: MD_NUM_LP MD_LP_PER Both: MD_NUM_BT MD_BT_PER
ALL PRESCRIBERS	ALL_DENOM	Glucose: ALL_NUM_GL ALL_GL_PER Lipid: ALL_NUM_LP ALL_LP_PER Both: ALL_NUM_BT ALL_BT_PER

WHAT WE ASK OF YOU?

Given the documented metabolic risks of antipsychotic medications, the monitoring of metabolic indices is important to ensure appropriate management of side effect risks, especially in children and adolescents. For your easy reference, are included is a list of your patients currently taking antipsychotics with no medical claims for metabolic screening during the previous year. We encourage that you will have someone in your office attach these labels to these patient charts as a reminder to order metabolic tests at the next patient visit

Sincerely,

Benjamin F. Banahan, III, Ph.D.
Project Director
MS-DUR

Judith P. Clark, R.Ph, B.S. Pharmacy
Director, Office of Pharmacy
Division of Medicaid



UPDATE ON FOLLOW-UP CARE FOR CHILDREN STARTING ADHD THERAPY

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. One measure in the current Child Core Set is "Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication."

At the February 2015 meeting of the DUR Board, the following recommendations were approved with respect to follow-up care for children starting ADHD 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.

An educational article is currently being written. Programming has been completed for the exceptions monitoring and educational intervention. Each month:

- An analysis will be run evaluating providers' performance on the quality measure
- Providers will be ranked based on the number of their patients who have filled an initial prescription for a stimulant and did not have a documented follow-up office visit within 30 days.
- The 100 providers with the greatest number of patients initiating therapy and not having a follow-up visit will be mailed a letter each month (see attached).
- A provider will only be sent one letter within a four month period of time.

The educational intervention will be continued for at least 6 months. After 6 months, MS-DUR will report on current performance within Medicaid and will make additional recommendations, if needed, to address this important quality-of-care measure. As with other quality-of-care related educational interventions, all children and providers in Medicaid, regardless of pharmacy plan, will be included in this initiative.

DATE

MD_NAME,
MD_ADDRESS
MD_ADDRESS, MS MD_ZIP

Dear Dr. MD_NAME,

The Mississippi Division of Medicaid (DOM) is committed to improving the quality of care provided to Mississippi Medicaid beneficiaries. DOM's Drug Utilization Review or DUR Board, comprised of twelve physicians and pharmacists from around the state, has recommended several initiatives addressing quality issues regarding the treatment of children with mental health illnesses. This letter is being sent as part of our initiative regarding appropriate follow up care when children begin stimulants for attention deficit/hyperactivity disorder (ADHD).

THE GOAL

The Children's Health Insurance Program Reauthorization Act of 2009 established the Pediatric Quality Measures Program. This is 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 Medicaid and the Children Health Insurance Program (CHIP). One measure in the current Child Core Set is the percentage of children initiating treatment with a stimulant for ADHD who had a follow-up visit within 30 days of starting therapy. A recent analysis of Mississippi Medicaid found that of the children beginning stimulant therapy only 59.3% had a follow-up visit within 30 days. The Mississippi rate is slightly above the national average reported in the 2014 CMS Annual Report but is far from ideal. It is recognized that appropriate management can occur without a claim for a follow up visit. However, this percentage should be much higher.

WHAT WE ASK OF YOU?

Analysis of Medicaid children (fee-for-service and coordinated care) during the last year showed that you initiated stimulant therapy for (MD_#PTS) children and (MD_%) had a claim for a follow-up visit within 30 days of filling the prescription. The American Academy of Pediatrics recommends that follow-up appointments should be made at least monthly until a child's mental and behavioral symptoms have been stabilized. When initiating treatment with stimulants, we encourage you to do monthly follow-ups until a stable treatment plan has been developed.

We recognize the challenges of diagnosing and establishing a stable treatment of ADHD. The Center for the Advancement of Youth (CAY) at the University of Mississippi Medical Center is working with DOM to provide coordinated care for youngsters with behavioral or developmental issues and to assist community physicians in diagnosing and developing treatment plans for children with ADHD and other behavioral problems. Please feel free to contact CAY to determine how they might help you provide effective coordinated care for children in your practice with behavioral problems. You can reach CAY by phone at their physician-to-physician number 866-862-3627 or by visiting their website <http://www.ummhealth.com/cay/>.

Sincerely,

Benjamin F. Banahan, III, Ph.D.
Project Director
MS-DUR

Judith P. Clark, R.Ph, B.S. Pharmacy
Director, Office of Pharmacy
Division of Medicaid

Resource Utilization Review

ENROLLMENT STATISTICS FOR LAST 6 MONTHS							
October 1, 2014 through March 31, 2015							
	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	
Total enrollment	729,156	731,978	753,450	758,963	758,184	753,460	
Dual-eligibles	154,743	154,744	152,671	154,202	154,054	153,670	
Pharmacy benefits	628,565	630,943	653,372	657,190	655,838	650,846	
LTC	17,643	17,562	17,466	17,536	17,295	17,050	
PLAN %	FFS	74.7%	74.7%	71.7%	71.5%	71.1%	68.5%
	MSCAN-UHC	11.4%	11.5%	13.4%	13.6%	13.8%	15.1%
	MSCAN-Magnolia	13.8%	13.9%	14.9%	15.0%	15.1%	16.4%

PHARMACY UTILIZATION STATISTICS FOR LAST 6 MONTHS							
September 1, 2014 through February 28, 2015							
	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	
# Rx Fills	FFS	275,600	256,429	299,888	280,766	331,853	250,228
	MSCAN-UHC	114,159	105,850	125,720	125,765	118,670	72,430
	MSCAN-Mag	149,126	145,291	165,743	212,079	151,735	166,991
# Rx Fills / Bene	FFS	0.6	0.5	0.6	0.6	0.7	0.6
	MSCAN-UHC	1.6	1.5	1.4	1.4	1.3	0.7
	MSCAN-Mag	1.7	1.7	1.7	2.2	1.5	1.6
\$ Paid Rx	FFS	\$24,519,119	\$21,777,833	\$27,243,044	\$25,382,906	\$29,933,250	\$25,290,631
	MSCAN-UHC	\$7,966,014	\$7,509,150	\$9,337,465	\$10,124,777	\$10,277,699	\$6,225,706
	MSCAN-Mag	\$9,342,897	\$10,263,743	\$11,955,898	\$16,629,694	\$12,407,501	\$13,521,016
\$ /Rx Fill	FFS	\$88.97	\$84.93	\$90.84	\$90.41	\$90.20	\$101.07
	MSCAN-UHC	\$69.78	\$70.94	\$74.27	\$80.51	\$86.61	\$85.95
	MSCAN-Mag	\$62.65	\$70.64	\$72.14	\$78.41	\$81.77	\$80.97
\$ /Bene	FFS	\$52.20	\$46.21	\$58.15	\$54.04	\$64.23	\$56.77
	MSCAN-UHC	\$110.78	\$103.85	\$106.89	\$113.70	\$113.56	\$63.26
	MSCAN-Mag	\$107.48	\$117.45	\$122.56	\$168.92	\$124.96	\$126.44

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 January, 2015 TO March, 2015

Generic Molecule	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
Anti-Inhibitor Coagulant Complex	\$288,269	\$451,017	\$884,140	4	5	5	3	3	4
Ledipasvir-Sofosbuvir	\$598,768	\$864,888	\$798,358	18	26	24	13	24	23
Antihemophilic Factor	\$599,394	\$554,811	\$748,672	29	26	23	19	21	20
Olopatadine Ophthalmic	\$118,420	\$128,052	\$195,940	655	679	1,017	620	565	1,005
Beclomethasone Nasal	\$24,233	\$50,243	\$61,237	174	339	413	166	285	411
Filgrastim	\$62,079	\$103,667	\$96,923	18	20	16	14	15	13
Dornase Alfa	\$176,455	\$204,145	\$209,492	53	56	58	47	48	56
Nilotinib	\$0	\$19,269	\$30,060	0	2	3	0	2	3
Linezolid	\$23,105	\$41,370	\$50,427	12	12	19	9	11	16
Epinephrine	\$186,617	\$205,357	\$211,916	446	490	505	425	418	502

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 January, 2015 TO March, 2015

Generic Molecule	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes	Incr. # Claims
Olopatadine Ophthalmic	\$118,420	\$128,052	\$195,940	655	679	1,017	620	565	1,005	362
Beclomethasone Nasal	\$24,233	\$50,243	\$61,237	174	339	413	166	285	411	239
Cetirizine-Pseudoephedrine	\$4,122	\$10,918	\$9,821	215	544	452	202	453	444	237
Epinephrine	\$186,617	\$205,357	\$211,916	446	490	505	425	418	502	59
Fluoride Topical	\$2,016	\$2,951	\$2,879	199	265	256	192	205	253	57
Ketotifen Ophthalmic	\$253	\$633	\$788	26	57	71	24	51	71	45
Tamsulosin	\$73,898	\$48,514	\$46,131	442	502	484	393	466	468	42
Vortioxetine	\$22,718	\$31,649	\$32,325	90	125	128	73	121	127	38
Benzoyl Peroxide-Erythromycin Topical	\$8,399	\$10,779	\$11,420	91	120	129	88	102	127	38
Moxifloxacin Ophthalmic	\$50,650	\$69,742	\$57,614	383	521	417	355	449	410	34

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

New Business

Special Analysis Projects

CLINICAL GUIDELINES FOR HYSINGLA™ ER

Description: On November 20, 2014 the FDA announced the approval of Purdue Pharma's Hysingla ER (hydrocodone bitartrate). The FDA has determined that Hysingla ER has properties that are expected to reduce, but not totally prevent, abuse of the drug when chewed and then taken orally, or crushed and snorted or injected. Hysingla ER is difficult to crush, break or dissolve. It also forms a viscous hydrogel when exposed to an aqueous environment that resist passage through a hypodermic needle. Hysingla ER is administered once daily (every 24 hours). For opioid-naïve and opioid non-tolerant patients, initiate with 20mg tablets PO every 24 hours. Increase the dose of Hysingla ER in increments of 10mg to 20mg every 3 to 5 days as needed to achieve adequate analgesia. Available strengths Oral Tablet, Extended Release : 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, and 120mg.

Indication: Hysingla ER is indicated for the management of pain severe enough to require daily, around the clock, long-term opioid treatment and for which alternative treatment options are inadequate. This product is not approved for as needed pain relief.

Black box warning summary from MicroMedex

- Prior to prescribing hydrocodone, assess each patient's risk for opioid addiction, abuse, and misuse and regularly monitor all patients for opioid addiction behaviors or conditions.
- Monitor for respiratory depression, which can be serious, life-threatening, or fatal, especially during initiation or following a dose increase, and instruct patients to swallow extended release capsules whole to avoid potentially fatal overdose.
- Fatal overdose can occur in children with accidental ingestion of just 1 dose of hydrocodone.
- If prolonged opioid use is necessary during pregnancy, advise the patient of the risk of life-threatening neonatal opioid withdrawal syndrome and arrange for appropriate treatment during and after delivery.
- Instruct patients to avoid alcoholic beverages or medications that contain alcohol to avoid a potentially fatal overdose.
- Concomitant use of a CYP3A4 inhibitor or discontinuation of a CYP3A4 inducer may increase or prolong adverse drug effects or cause potentially fatal respiratory depression.

Current Mississippi Medicaid Uniform Preferred Drug List (UPDL)

ANALGESICS, NARCOTIC - LONG ACTING <small>SmartPA</small>			
THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	fentanyl patches methadone morphine ER tablets OPANA ER (oxymorphone)	AVINZA (morphine) BUTRANS (buprenorphine) CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EMBEDA (morphine/naltrexone) EXALGO (hydromorphone) hydromorphone ER HYSINGLA ER (hydrocodone) ^{MS} KADIAN (morphine) MS CONTIN (morphine) morphine ER capsules NUCYNTA ER (tapentadol) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER RYZOLT (tramadol) tramadol ER ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/APAP) ZOHYDRO ER (hydrocodone bitartrate)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> 18 years – Xartemis XR, Zohydro ER <p>Quantity Limits</p> <p>Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> 31 tablets/31 days – Avinza, Exalgo ER, Hysingla ER, Ultram ER, Ryzolt, Conzip ER 62 tablets/31 days – Methadone, Kadian, Morphine ER, Embeda, oxycodone ER, Opana ER, Oxycontin, Zohydro ER 10 patches/31 days – Duragesic 4 patches/31 days – Butrans 40 tablets/10 days – Xartemis XR <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR Documented diagnosis of cancer OR Antineoplastic therapy AND 90 consecutive days on same agent in the past 105 days

Possible Criteria for Consideration by Board:

The following potential criteria and areas for discussion have been identified by MS-DUR and DOM.

Age edit	Minimum age of 18 years
Quantity limit	Maximum 1 unit per day,
Diagnosis	Documented diagnosis of cancer
Step-therapy	Prior 30 days of therapy with 2 different preferred agents in the past 12 months AND Prior 30 days therapy with 2 different non-preferred agents in the past 12 months

Recommendation:

The DUR Board recommends that DOM adopt the product specific PA criteria for use of Hysingla ER identified during the discussion.

OVERVIEW OF UNIFORM PREFERRED DRUG LIST (UPDL) MONTHLY REVIEW

BACKGROUND

In 2014, the Division of Medicaid (DOM) began development of a Uniform Preferred Drug List (UPDL) for use in the Medicaid pharmacy program. The objectives of the UPDL were (1) to make treatment of Medicaid beneficiaries easier for providers by having the same preferred drug list regardless of pharmacy program (fee-for-service or coordinated care plan), (2) to maximize pharmacy rebates to Medicaid in order to reduce to cost of care delivered, and (3) to assure that similar services are provided to Medicaid beneficiaries regardless of health plan. The UPDL was implemented in January 2015 and with coordinated care contracts requiring compliance with the UPDL. Since compliance with a preferred drug list is complicated and changes occur in the UPDL throughout the year, MS-DUR was asked by DOM to add a monthly compliance monitoring program to its contract deliverables. The purpose of the monthly report is to help DOM monitor UPDL compliance and identify problem areas that need to be addressed in any of the three pharmacy programs.

METHODS AND REPORT SAMPLES

MS-DUR will maintain a database of the monthly preferred/non-preferred status of all products included in the UPDL starting with January 2015. Each month MS-DUR will provide DOM a detailed report summarizing the status of all claims for the products in the UPDL. The Monthly UPDL Compliance Report will include three major tables:

1. A summary of the number of claims and the percent of claims for non-preferred agents for each of the last 3 months broken down by each reviewed category/subcategory of agents in the UPDL.
2. A detailed breakdown for each UPDL category/subcategory identifying preferred/non-preferred use for the prior month by individual agent at the brand/generic, strength and dosing form levels.
3. A summary for the last month for each reviewed category/subcategory of the prior authorization (PA) source for each non-preferred agent used in the FFS program.

Tables 1 and 2 will be reported for each Medicaid pharmacy program (FFS, Magnolia Health Care, and United Health Care). An abbreviated example of how the monthly UPDL Compliance Report will be used by DOM is given below for the oral antipsychotic class. The January 2015 UPDL for this class is shown below.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIPSYCHOTICS	ORAL		
	ABILIFY (aripiprazole) amitriptyline/perphenazine chlorpromazine clozapine FANAPT (loperidone) fluphenazine GEODON (ziprasidone) haloperidol risperidone SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) thioridazine trifluoperazine ZYPREXA (olanzapine)	CLOZARIL (clozapine) FAZACLO (clozapine) HALDOL (haloperidol) INVEGA (paliperidone) LATUDA (lurasidone) NAVANE (thiothixene) olanzapine olanzapine/fluoxetine quetiapine RISPERDAL (risperidone) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clozapine) ziprasidone	Minimum Age Limits 3 years - haloperidol 5 years - risperidone 6 years - aripiprazole 10 years - olanzapine/fluoxetine, quetiapine 13 years - olanzapine 18 years - asenapine, clozapine, loperidone, lurasidone, baliperidone, ziprasidone

Table 1 will be used to identify UPDL categories / subcategories where a larger than expected percentage of non-preferred product use is occurring or where use of non-preferred agents is not consistent across pharmacy programs. The current shift of most children to coordinated care will result in the patient population in the FFS program being somewhat different than that of the two coordinated care plans. This will result in utilization differences between FFS and coordinate care plans for many therapeutic categories. However, utilization that does occur in each therapeutic category should have similar rates of non-preferred agent use across the three programs. The last three months will be reported in order to identify increasing or decreasing trends in non-preferred use. A sample Table 1 based on actual data is shown below for the oral antipsychotic category.

TABLE 1 MISSISSIPPI DIVISION OF MEDICATION PDL COMPLIANCE* REPORT PDL CATEGORY SUMMARY BY PLAN REPORT PERIOD January 2015 - March 2015 <i>(EXAMPLE FOR BOARD DISCUSSION ONLY)</i>							
		Prescription Plan					
		FFS		Magnolia		UHC	
CATEGORY	Month	Total # Claims	% Non-preferred	Total # Claims	% Non-preferred	Total # Claims	% Non-preferred
Antipsychotics: Oral	Jan 2015	5,654	3.5%	4,917	13.5%	3,203	8.9%
	Feb 2015	6,292	3.2%	3,654	13.7%	3,145	4.7%
	Mar 2015	5,629	3.1%	3,933	13.2%	1,997	4.6%

Non-preferred product use is not always expected to be 0%. In many categories there will be medically acceptable reasons why non-preferred agents are needed. When this occurs, it is expected that PAs will be approved for use of non-preferred products. Use of non-preferred agents will also be expected to occur when a change in preferred status has taken place and use of the previously preferred product is being “grandfathered.” Grandfathering is allowed when DOM has determined that abruptly forcing providers and patients to change to a preferred agent will be

overly disruptive to care. In these cases, patients who have been on stable therapy on the previously preferred product will be allowed to continue on that regimen for a specified period of time or until they need a change in therapy. When grandfathering is allowed, any new starts in therapy will be required to use a preferred agent. When a UPDL change occurs and grandfathering is allowed for the drug product, it will be expected that non-preferred use of the agent will occur immediately after the change in UPDL status, but non-preferred use will decline over time as prescribers have to make changes in therapy for these patients.

When the rate of non-preferred use is considered to be higher than expected, Table 2 will be used to identify the specific products being used by brand/generic status, strength and dosage form. Information in this table will allow MS-DUR and DOM to identify the specific agents resulting in non-preferred product use and to determine what actions are needed, when appropriate, to assure more appropriate compliance with the UPDL. The example section of Table 2 below illustrates how DOM will be able to determine exactly where non-compliance is occurring. Examples of how the information in Table 2 will be used to evaluate the use of non-preferred agents are given below:

- A small number of patients received brand Clozaril instead of the preferred generic of this agent. This occurred in two of the three pharmacy programs. Unless the prescriber has requested a PA for use of the brand for medically necessary reasons, these cases usually will be the result of grandfathering being extended to generic status instead of the agent itself. In therapeutic categories that are considered to be narrow therapeutic index drugs, DOM may decide that grandfathering will be done at the brand/generic level. However, usually this is not the case and use of non-preferred brands is an issue that will need to be addressed in the PA process.
- In all three pharmacy plans a large number of claims occurred for generic Olanzapine instead of the preferred brand product Zyprexa. Detecting this non-preferred drug use is important since it can result in a significant loss in rebates to DOM. Again, non-preferred product use such as this indicates a problem that needs to be addressed in the adjudication process or PA process.
- Invega moved to non-preferred in January, thus all claims for this product are currently non-preferred. The use currently taking place is an example of grandfathering being allowed when the change in status occurred. MS-DUR and DOM will watch these numbers over time to be sure non-preferred use declines as patients change to other therapies over time.

TABLE 2
MISSISSIPPI DIVISION OF MEDICATION PDL COMPLIANCE* REPORT
PDL CATEGORY DRUG LEVEL DETAIL BY PLAN
REPORT MONTH March 2015
(EXAMPLE FOR BOARD DISCUSSION ONLY)

				Prescription Plan					
				FFS		Magnolia		UHC	
				PDL Status		PDL Status		PDL Status	
	Form	Product	Strength	Non-preferred	Preferred	Non-preferred	Preferred	Non-preferred	Preferred
Antipsychotics: Oral	TABLET	CLOZAPINE	100 MG		165		110		109
		CLOZARIL		2				3	
		CLOZAPINE	200 MG		4		9		6
		CLOZAPINE	25 MG		53		15		10
		CLOZARIL		3					
		CLOZAPINE	50 MG		2				
	TABLET	OLANZAPINE	10 MG	19		206		39	
		ZYPREXA			272		23		160
		OLANZAPINE	15 MG	3		151		29	
		ZYPREXA			110		10		92
		OLANZAPINE	20 MG	22		310		62	
		ZYPREXA				142		18	
	TABLET	QUETIAPINE FUMARATE	25 MG			10			
		SEROQUEL			342		93		101
		QUETIAPINE FUMARATE	50 MG			17		1	
		SEROQUEL			699		180		268
		QUETIAPINE FUMARATE	100 MG	1		45		3	
		SEROQUEL			765		597		361
		QUETIAPINE FUMARATE	200 MG	4		39			
		SEROQUEL			463		476		385
	TABLET, EXTENDED RELEASE	INVEGA	1.5 MG	9		3			
		INVEGA	3 MG	21		28		16	
		INVEGA	6 MG	43		99		40	
INVEGA		9 MG	42		57		45		

CONCOMITANT USE OF NALTREXONE AND BUPROPION FOR WEIGHT CONTROL

BACKGROUND

In September 2014, the FDA approved Contrave[®], a combination product containing naltrexone (8mg) and bupropion (90mg). This product is indicated as a treatment option for chronic weight management. Contrave[®] is approved for use in adults with a body mass index (BMI) of 30 kg/m² or greater (obese) or adults with a BMI of 27 kg/m² or greater (overweight) who have at least one weight-related condition, such as hypertension, type 2 diabetes or dyslipidemia. As required by Federal guidelines, Mississippi Division of Medicaid (DOM) does not cover weight loss products and thus will not be covering Contrave[®]. However, the active ingredients of Contrave[®] are available as single-entity products. Naltrexone, available as a 50mg tablet, is approved for the treatment of alcohol dependence. Although 50mg is much higher than the 8mg included in Contrave[®], all tablets available are scored and easily split. Bupropion, available in 75mg, 150mg and 300mg strengths, is used to treat depression and as an aid to smoking cessation treatment.

This issue was reported to the November 2014 Board meeting and the Board made a recommendation that a clinical edit should be put in place to prevent concomitant use of the individual products. Prior to the Board meeting, MS-DUR analysis found that only one case of concomitant use had occurred in 2014. MS-DUR recently ran a follow-up analysis to determine if providers have started prescribing concomitant use of the products as potential weight loss treatment.

METHODS

MS-DUR conducted an analysis of prescriptions for naltrexone and bupropion since this issue was last reported in November 2014. A retrospective analysis was conducted using all Mississippi Medicaid pharmacy claims and encounters for the period November 1, 2014 through March 31, 2015. All prescriptions for naltrexone and bupropion were extracted and beneficiaries were identified if concomitant use of both products occurred.

RESULTS

Table 1 shows the results of the first analysis reported at the November 2014 Board Meeting. During the first 2 months after approval of Contrave[®] only 1 beneficiary was prescribed the two products concomitantly.

TABLE 1: NUMBER OF BENEFICIARIES TAKING NALTREXONE AND BUPROPION (January 2014 - October 2014)			
	FFS	UHC	Magnolia
Naltrexone	40	7	10
Bupropion	773	1090	1523
Both	0	1	0

Table 2 shows the utilization of Naltrexone and Bupropion starting in November 2014. It appears that some providers are attempting to use the two product concomitantly. 8 beneficiaries have been concomitantly taking the two products. In two of these cases, the prescribers were different. However, in the other 6 cases, both medications were prescribed by the same provider. Since this prescribing behavior did not occur before approval of Contrave®, it can only be concluded that these providers are prescribing the two products together for weight control.

TABLE 2: NUMBER OF BENEFICIARIES TAKING NALTREXONE AND BUPROPION (November 2014 - March 2015)			
	FFS	UHC	Magnolia
Naltrexone	41	6	18
Bupropion	605	1247	1766
Concomitant use of both	2	0	6

CONCLUSIONS

- It appears that some providers are trying to use Naltrexone and Bupropion together for weight control. Concomitant use should be prevented without prior authorization (PA). Concomitant use could be monitored through electronic PA or since there is little use of Naltrexone, it could be accomplished by requiring manual PA for Naltrexone.

RECOMMENDATION

MS-DUR makes the following recommendations to the Board:

- DOM and the coordinated care plans should implement a clinical edit that would prevent concomitant use of the two products without manual prior authorization (PA) and documentation of medical necessity.

Evaluation of Potential Criteria for Use of Multiple Hypoglycemic Agents

BACKGROUND

The Division of Medicaid (DOM) has been exploring development of prior authorization (PA) criteria regarding the use of multiple diabetic agents. The 2015 ADA guidelines for secondary agents are very vague. Older guidelines from the ADA & European Association for the Study of Diabetes are a little more specific, but still do not list a clear roadmap. Gould Health Services (GHS), DOM's rebate and PDL management vendor, proposed the following recommendations based on guidelines published by Up To Date:

- Patients can use up to 3 preferred agents for diabetes (metformin, sulfonylurea, TZD, DPP-4 Inhibitor, Meglitinide, GLP-1 Agonist or insulin) in any combination.
- Metformin should be included in every regimen unless contraindicated.
- The following combinations should not be permitted without PA:
 - Sulfonylureas + insulin
 - Sulfonylureas + meglitinides
 - DPP-4 Inhibitors + GLP-1 Agonist
- Use of combination products count as two agents (i.e. Janumet contains sitagliptin and metformin...this counts as two of the three preferred agents).
- Prior to use of a 4th agent, a PA would be required with an explanation as to why insulin would be contraindicated. If insulin is part of the original 3 drug regimen, an explanation as to why the dose cannot be tapered up would be required prior to adding a 4th agent.
- Use of a GLP-1 Agonist would be considered if weight loss is needed and the patient is close to A1C goals ($\leq 1\text{mg/dL}$).
- Use of an SGLT-2 Inhibitor would be considered if the patient could not take insulin.
- Approved PAs for a 4th agent would require a re-evaluation every 6 months with updated A1C values for proof that the regimen of 4 agents is yielding positive outcomes/results

MS-DUR was asked to analyze current use patterns of diabetic agents in order to assist DOM in evaluating the potential impact of the proposed multiple agent PA criteria.

METHODS

A retrospective analysis was conducted using all Mississippi Medicaid (fee-for-service and coordinated care) pharmacy claims data for the period July 1, 2014 to February 28, 2015. All antidiabetic product claims were extracted for analysis.

Identification of multiple agent regimens was performed using the following criteria:

- Patients were considered to be “covered” by a product between the time of the first prescription fill identified and the date of the last prescription fill plus the number of days therapy of the last fill.
- Medication possession gaps of less than 60 days were considered to be compliance gaps and the patient was considered to still be covered by the product during these compliance gaps.
- For each day during the observation period, coverage arrays were computed for each drug product being taken by the patient. Combination products were recorded as coverage for both therapeutic classes included in the product.
- For each patient, a regimen was computed for each day that included all of the therapeutic classes for which the patient had coverage.
- When coverage of a discontinued therapeutic category resulted in an overlap of less than 30 days from the initiation of new therapeutic category, the overlap period for the discontinued category was eliminated under the assumption that the overlap only occurred due to residual possession of the drug after a patient’s regimen was changed.
- Any therapy combinations that had continuous coverage of < 30 days were eliminated as titration or incidental occurrences.

The antidiabetic therapeutic classes used to classify regimens are listed in Table 1.

RESULTS

TABLE 2: Number of Different Regimens Used During Observation Period		
Number of Regimens*	N	%
0	2,025	12.2%
1	4,788	28.9%
2	3,943	23.8%
3	3,028	18.3%
4	1,888	11.4%
5	747	4.5%
6	145	0.9%
7	10	0.1%

* Regimens were identified as therapeutic combinations with > 30 days consecutive coverage.

TABLE 1: Antidiabetic Therapy Classes Used to Determine Regimen Combinations	
Antidiabetic Agent Classes	
Abbreviation in Regimens	Description
Sulf	Sulfonylureas
Metf	Metformin
TZD	Thiazolidinediones
Megl	Meglitinides
DPP4	Dipeptidyl peptidase 4 inhibitors
GLP1	Glucagon-like peptide-1 receptor agonists
Insu	Insulin
SGLT	Sodium-glucose transporter-2 inhibitors
Amyl	Amylin analogs
AI GI	Alpha-glucosidase inhibitors

A total of 16,574 beneficiaries were identified as taking antidiabetic agents during the observation period. As shown in Table 2, 2,025 of these beneficiaries did not take a steady regimen for 30 days or more. These may have been newly diagnosed patients that did not reach a stable therapy during the observation period or one-time users of an antidiabetic agents.

The results in Table 2 also illustrate the instability of diabetic treatment over time. Only 29% of the diabetic patients treated during the observation period remained on the same regimen for the complete 242 days observed. Almost one-fourth made only 1 change in regimen. However, almost two-thirds of patients made 2 or more regimen changes during the observation period.

Table 3 shows the different regimens being used for > 30 days during the observation period. Overall there were 33,985 patient/regimen combinations during the observation period. The frequency cells for cases using regimens with more than 3 agents are highlighted in dark orange.

TABLE 3: Regimens Used to Treat Beneficiaries During Observation Period							
Regimen	N	Average # Days	Maximum # Days	Regimen	N	Average # Days	Maximum # Days
Sulf	3,366	38.9	232	Megl	9	33.3	60
Sulf	127	32.9	90	DPP4	762	41.6	175
Sulf / AIgl	4	46.3	95	DPP4 / GLP1	5	48.0	90
Sulf / DPP4	155	36.1	110	GLP1	117	35.3	90
Sulf / DPP4 / SGLT	4	41.0	59	SGLT	27	36.0	90
Sulf / GLP1	10	40.1	90	Insu	10,575	40.0	237
Sulf / Metf	2,760	38.7	217	Insu / AIgl	6	48.2	60
Sulf / Metf / AIgl	7	55.7	120	Insu / DPP4	140	38.1	120
Sulf / Metf / DPP4	300	39.6	179	Insu / GLP1	18	43.2	119
Sulf / Metf / GLP1	7	37.3	56	Insu / Megl	3	66.7	109
Sulf / Metf / SGLT	3	30.3	31	Insu / Megl / DPP4	2	47.5	65
Sulf / Metf / TZD	65	38.3	148	Insu / Metf	1,240	38.2	180
Sulf / Metf / TZD / DPP4	6	34.5	52	Insu / Metf / DPP4	50	38.7	127
Sulf / Metf / TZD / DPP4	3	80.0	180	Insu / Metf / DPP4	26	39.6	120
Sulf / Metf / TZD / GLP1	2	30.0	30	Insu / Metf / DPP4 / SGLT	1	30.0	30
Sulf / SGLT	3	30.0	30	Insu / Metf / GLP1	1	30.0	30
Sulf / TZD	52	38.7	94	Insu / Metf / TZD	10	43.8	89
Sulf / TZD / DPP4	5	41.4	60	Insu / Metf / TZD / DPP4	1	30.0	30
Metf	11,965	38.5	228	Insu / SGLT	6	39.5	60
Metf / AIgl	1	30.0	30	Insu / Sulf	369	38.5	180
Metf / DPP4	452	39.4	233	Insu / Sulf / DPP4	15	37.3	59
Metf / DPP4	400	42.7	180	Insu / Sulf / Metf	294	37.3	127
Metf / DPP4 / GLP1	38	44.1	120	Insu / Sulf / Metf / DPP4	21	37.8	60
Metf / DPP4 / SGLT	2	30.0	30	Insu / Sulf / Metf / SGLT	1	30.0	30
Metf / GLP1	17	40.6	81	Insu / Sulf / Metf / TZD	6	49.5	82
Metf / Megl	1	30.0	30	Insu / Sulf / Metf / TZD / DPP4 / AIgl	3	49.7	60
Metf / SGLT	6	40.0	90	Insu / Sulf / TZD	6	42.8	77
Metf / TZD	175	42.8	226	Insu / TZD	36	39.3	99
Metf / TZD / DPP4	14	48.4	115	Insu / TZD / DPP4	7	38.3	60
TZD	264	42.7	150				
TZD / DPP4	14	35.4	60				

* Regimens were identified as therapeutic combinations with > 30 days consecutive coverage.

NOTE: List includes all regimens appearing during observation period. Beneficiaries are included for each regimen used during observation period.

Requiring a manual PA for regimens using more than 3 agents would not produce a heavy burden for the manual PA process if these could be identified without having to manually screen all diabetic agent prescriptions. Only 44 cases occurred during the observation period where patients were treated with more than 3 agents for more than 30 days.

Requiring Metformin to be part of every regimen except when contraindicated might be more challenging. Of the 33,985 patient/regimen combinations occurring, only 17,878 (52.6%) included Metformin. Although Metformin might be contraindicated in some of the other regimen combinations present, there may be a large number of cases that would have to be reviewed for possible Metformin inclusion. Detecting this prospectively or even retrospectively will be complicated by the fact that Metformin is on most \$4 prescription lists and many patients may be paying cash if they are at the prescription limit in Medicaid.

Of the contraindicated regimens identified in the recommendations, concomitant use of Sulfonylureas and Insulin would produce the greatest number of PA reviews (715). Only 43 cases were identified with concomitant use of a GLP-1 and a DPP-4 and no cases were identified with concomitant use of Sulfonylureas and Meglitinides.

CONCLUSIONS

Implementation of diabetic agent prior authorization criteria will not be cost effective if electronic PA is not used. Even using electronic PA will be problematic due to:

- the large number of changes in regimen that occur,
- the difficulty of identifying concomitant coverage of multiple drugs, and
- the need to break down combination products into their corresponding individual agents.

Contraindicated regimens are occurring infrequently.

- Concomitant use of Sulfonylureas and Insulin only occurred 715 times.
- Concomitant use of GLP-1 and DPP-4 only occurred 43 times.
- Concomitant use of Sulfonylureas and Meglitinides did not occur at all.

Current treatment patterns among DOM beneficiaries with diabetes are fairly well in compliance with the recommended criteria with the exception of including Metformin in almost all regimens. Accurately determining whether Metformin is being used will be difficult since this product is included in almost all "\$4" prescription plans and prescriptions paid for in cash are not included in the data for analysis.

Recommendations:

Electronic PA should be used to the extent possible to assure compliance with guidelines.

Retrospective DUR educational programs should be utilized to address cases that do not comply with the approved guidelines.

- Use of regimens with more than 3 agents should be identified through retrospective DUR with intervention through educational feedback to providers.
- Use of contraindicated regimens should be addressed through retrospective DUR exceptions monitoring with appropriate educational interventions.

Action Needed:

- DUR Board input on appropriateness of proposed guidelines.
- DUR Board support for educational intervention programs.

OVERVIEW OF OFFICE OF INSPECTOR GENERAL REPORT ON ANTIPSYCHOTIC DRUG USE IN MEDICAID CHILDREN

BACKGROUND

In March 2015, the Office of the Inspector General (OIG) of the Department of Health and Human Services issued a report titled, "Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns." In the report, the rationale for their study was described as:

Second-generation antipsychotics (SGAs) are a class of drugs used to treat psychiatric disorders, such as schizophrenia, bipolar disorder, and psychotic depression. SGAs are widely used to treat children enrolled in Medicaid who have mental health conditions. However, SGAs can have serious side effects and little clinical research has been conducted on the safety of treating children with these drugs. Consequently, children's treatment with SGAs needs careful management and monitoring. This evaluation examines the quality of care provided to children receiving SGAs that were paid for by Medicaid.

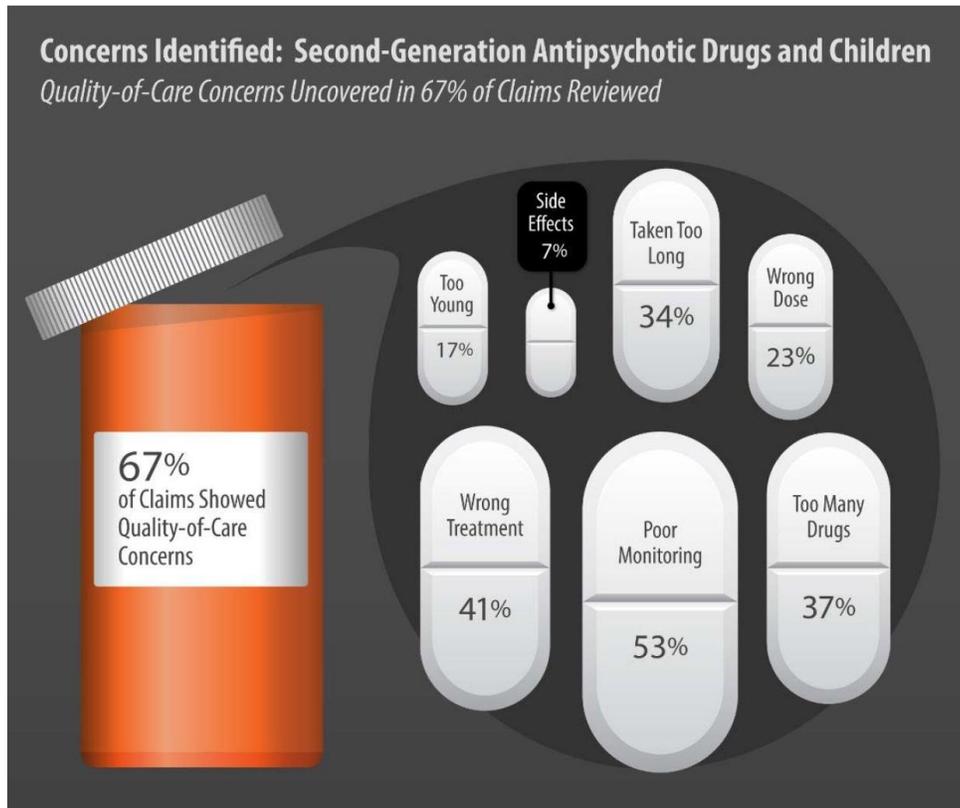
The OIG study selected 687 claims for SGAs prescribed to children in California, Florida, Illinois, New York and Texas. Board-certified child and adolescent psychiatrists reviewed medical records related to these claims using seven criteria related to quality-of-care concerns. The seven criteria were established on the basis of information and guidelines issued by various Federal and State agencies and professional associations regarding the prescribing of psychotropic drugs to children. The seven quality of care criteria evaluated by the OIG included:

- **Appropriate dosage** – treatment should start with the lowest effective dose; the dose should be adjusted and targeted; the dosage should not exceed any recommended dosage guidelines.
- **Duration of use** – dose reduction should be planned after several months of treatment; treatment plans should include a plan for discontinuing the drug; medication trials should be of adequate duration to assess the effects of the drug.
- **Indications for use** – prescribed drugs should be consistent with the child's diagnosis. There should be a complete evaluation of all aspects of a child's condition and situation – including a complete medical history and a psychiatric evaluation; the target symptoms and diagnosis for each drug a child is prescribed should be clearly documented. In most instances, psychosocial interventions should be tried before starting treatment with drugs.
- **Monitoring** – monitoring should include child's response to the drug, observation of physiological changes, and observation of side effects.
- **Polypharmacy** – a single drug should be tried before treatment with multiple drugs; needs to be clearly documented rationale for each drug when a child is treated with multiple drugs.

- **Side effects** – side effects should be closely monitored; specific measures to monitor side effects include taking baseline and ongoing measures for height, weight, blood pressure, and body mass index, as well as measuring baseline and ongoing blood glucose and lipid levels.
- **Patient age** – treatment of young children with SGAs should be rare and carefully managed; “young children” are defined in guidelines as those under 4 years of age or under 6 years of age.

ISSUES IDENTIFIED BY OIG AND RECOMMENDATIONS

Quality-of-care concerns were identified in the medical records of 67% of the sampled claims for SGAs prescribed to children.



OIG made three recommendations to the Centers for Medicare and Medicaid Services (CMS).

1. **CMS should work with State Medicaid programs to perform utilization reviews of SGAs prescribed to children.**
2. CMS should work with State Medicaid programs to conduct periodic reviews of medical records associated with claims for SGAs prescribed to children.

3. CMS should work with States to consider other methods of enhanced oversight of SGAs prescribed to children, such as implementing peer review programs.

CMS concurred with all three recommendations.

OIG stated that utilization reviews could specifically focus on the children's age, the duration of their treatment with SGAs, and their overall drug regimens. Utilization guidances developed by the Florida and Texas Medicaid programs were identified as being of use to CMS and other states in developing guidelines for utilization reviews.

BOARD ACTION

MS-DUR wanted to present an overview of OIG report today. We will be presenting a detailed review of the Florida and Texas utilization guidances at the next meeting with a summary of related current utilization monitoring and management efforts by DOM and recommendations for discussion about additional DUR activities needed.

Handout for next meeting: Department of Health and Human Services Office of the Inspector General. Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns.

<http://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf>

Exceptions Monitoring Criteria Recommendations

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

Criteria Recommendations

1. Co-administration of Atripla (efavirenz/emtricitabine/tenofovir disoproxil fumarate) with voriconazole

Message: In January 2015, the FDA issued a contraindication that Atripla tablets should not be used in combination with voriconazole because it can reduce the plasma concentration and effectiveness of voriconazole, while increasing plasma concentration and side-effects of efavirenz.

Exception Type: DDI - Drug-drug interaction

Field 1

Atripla tablet

Field 2

Voriconazole

References:

FDA Drug Safety Labeling Changes. January 2015. Available at:
<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm225300.htm>

2. Co-administration of Isordil Titrados (isosorbide dinitrate) tablets with phosphodiesterase inhibitors or riociguat

Message: In January 2015, the FDA issued a contraindication that Isordil Titrados tablets should not be used in combination with phosphodiesterase inhibitors such as sildenafil, tadalafil, or vardenafil (used for the treatment of erectile dysfunction) because it can cause severe hypotension, syncope, or myocardial ischemia. The FDA also contraindicates administration of Isordil Titrados tablets in patients who are taking the soluble guanylate cyclase stimulator riociguat as it can cause hypertension.

Exception Type: DDI - Drug-drug interaction

Field 1

Isordil Titrados tablets

Field 2

Phosphodiesterase inhibitors such as such as sildenafil, tadalafil, or vardenafil.
Soluble guanylate cyclase stimulator riociguat

References:

FDA Drug Safety Labeling Changes. January 2015. Available at:
<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm433322.htm>

3. Co-administration of Lotensin tablets (benazepril hydrochloride) with aliskiren in patients with diabetes.

Message: In January 2015, the FDA issued a contraindication for co-administration of aliskiren with angiotensin receptor blockers, ACE inhibitors, including Lotensin in patients with diabetes.

Exception Type: DDI - Drug-drug interaction

Field 1

Aliskiren

Field 2

angiotensin receptor blockers, ACE inhibitors, including Lotensin in patients with diabetes

References:

FDA Drug Safety Labeling Changes. January 2015. Available at:
<http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm194338.htm>

Appendix

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

Generic Molecule	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
Montelukast	\$2,010,250	\$2,124,743	\$2,016,124	10,312	10,773	10,219	9,811	8,994	10,013
-----Singular	\$1,976,538	\$2,096,714	\$1,989,674	9,997	10,506	9,972	9,509	8,758	9,768
-----Montelukast Sodium	\$33,712	\$28,029	\$26,450	315	267	247	305	236	246
Aripiprazole	\$1,807,087	\$1,844,182	\$1,728,734	2,262	2,330	2,175	1,994	1,990	2,035
-----Abilify	\$1,784,936	\$1,818,391	\$1,715,283	2,246	2,311	2,166	1,979	1,977	2,026
-----Abilify Discmelt	\$10,509	\$14,051	\$6,743	9	12	5	9	9	5
-----Abilify Maintena	\$11,642	\$11,740	\$6,708	7	7	4	7	5	4
Lisdexamfetamine	\$1,774,219	\$1,919,541	\$1,671,481	7,900	8,387	7,328	7,470	6,841	7,055
-----Vyvanse	\$1,774,219	\$1,919,541	\$1,671,481	7,900	8,387	7,328	7,470	6,841	7,055
Quetiapine	\$1,613,415	\$1,525,258	\$1,364,169	3,134	2,919	2,583	2,570	2,471	2,309
-----Seroquel	\$1,268,368	\$1,184,728	\$1,046,934	2,597	2,406	2,114	2,144	2,032	1,893
-----Seroquel Xr	\$288,493	\$301,762	\$279,206	407	430	390	338	380	365
-----Quetiapine Fumarate	\$56,553	\$38,769	\$38,029	130	83	79	97	75	74
Methylphenidate	\$1,367,131	\$1,397,741	\$1,242,455	6,796	6,900	6,067	5,950	5,493	5,510
-----Methylphenidate Hydrochloride Er	\$926,517	\$910,974	\$799,343	4,326	4,271	3,713	3,922	3,569	3,512
-----Quillivant Xr	\$175,587	\$208,191	\$186,823	676	791	710	656	655	687
-----Metadate Cd	\$167,991	\$179,525	\$168,181	646	681	632	590	552	604
-----Daytrana	\$66,584	\$69,360	\$61,838	257	266	236	246	222	230
-----Methylphenidate Hydrochloride	\$13,992	\$14,833	\$12,564	816	829	724	745	688	674
-----Methylin	\$9,042	\$7,653	\$8,355	27	26	24	26	20	22
-----Ritalin La	\$1,522	\$1,588	\$2,040	7	7	9	7	5	9

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	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
-----Methylphenidate Hydrochloride Sr	\$3,299	\$2,520	\$1,503	26	15	11	25	12	11
-----Concerta	\$1,399	\$2,418	\$1,445	5	8	5	4	5	5
Oseltamivir	\$1,848,254	\$1,884,078	\$1,015,362	10,623	10,397	5,622	10,201	8,702	5,598
-----Tamiflu	\$1,848,254	\$1,884,078	\$1,015,362	10,623	10,397	5,622	10,201	8,702	5,598
Amphetamine-Dextroamphetamine	\$1,061,855	\$1,064,083	\$922,547	6,814	6,804	5,904	5,608	5,173	5,093
-----Adderall Xr	\$855,892	\$862,597	\$747,631	3,647	3,683	3,182	3,296	3,071	3,035
-----Amphetamine-Dextroamphetamine	\$197,596	\$194,743	\$169,916	3,114	3,081	2,693	2,757	2,531	2,493
-----Amphetamine-Dextroamphetamine Er	\$7,966	\$6,065	\$4,060	52	37	26	41	36	25
-----Adderall	\$401	\$677	\$940	1	3	3	1	3	3
Anti-Inhibitor Coagulant Complex	\$288,269	\$451,017	\$884,140	4	5	5	3	3	4
-----Feiba Nf	\$288,269	\$451,017	\$884,140	4	5	5	3	3	4
Insulin Glargine	\$1,006,135	\$906,733	\$817,073	2,234	2,007	1,793	1,927	1,850	1,742
-----Lantus	\$823,138	\$715,094	\$636,078	1,832	1,582	1,410	1,576	1,463	1,371
-----Lantus Solostar Pen	\$182,998	\$191,639	\$180,996	402	425	383	359	389	376
Budesonide	\$916,502	\$996,310	\$810,996	2,105	2,255	1,877	1,998	1,850	1,843
-----Pulmicort Respules	\$874,566	\$961,419	\$773,370	1,909	2,066	1,694	1,813	1,688	1,665
-----Pulmicort Flexhaler	\$30,510	\$31,247	\$28,301	180	184	165	170	160	162
-----Budesonide	\$11,426	\$3,644	\$9,326	16	5	18	16	5	18
Ledipasvir-Sofosbuvir	\$598,768	\$864,888	\$798,358	18	26	24	13	24	23
-----Harvoni	\$598,768	\$864,888	\$798,358	18	26	24	13	24	23

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	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
Antihemophilic Factor	\$599,394	\$554,811	\$748,672	29	26	23	19	21	20
-----Eloctate With Fc Fusion Protein	\$159,594	\$146,060	\$289,766	2	2	3	2	2	3
-----Advate Rahf-Pfm	\$147,213	\$177,368	\$282,248	7	8	9	5	8	7
-----Recombinate	\$190,684	\$152,703	\$109,805	10	8	4	5	6	4
-----Kogenate Fs With Adapter	\$34,715	\$51,004	\$28,408	1	2	1	1	1	1
-----Hemofil-M	\$19,497	\$0	\$19,017	1	0	1	1	0	1
-----Helixate Fs	\$5,500	\$5,500	\$10,491	2	2	1	1	1	1
-----Advate	\$29,081	\$7,427	\$8,937	5	3	4	4	3	4
Albuterol	\$862,415	\$894,071	\$710,032	18,434	18,993	14,841	15,402	14,925	13,212
-----Albuterol Sulfate	\$284,225	\$311,626	\$224,164	8,601	9,394	6,802	7,845	7,757	6,567
-----Ventolin Hfa	\$273,758	\$257,318	\$213,723	5,205	4,809	4,012	4,682	4,326	3,925
-----Proventil Hfa	\$174,109	\$190,358	\$155,473	2,308	2,467	2,022	2,207	2,055	1,978
-----Proair Hfa	\$129,775	\$134,179	\$115,947	2,301	2,306	1,985	2,066	2,024	1,959
Guanfacine	\$692,513	\$747,578	\$641,195	4,688	4,942	4,320	4,339	4,069	4,100
-----Guanfacine Hydrochloride	\$328,181	\$418,001	\$371,950	3,515	3,872	3,447	3,249	3,233	3,295
-----Intuniv	\$364,332	\$329,577	\$269,245	1,173	1,070	873	1,118	852	822
Dexmethylphenidate	\$636,930	\$705,587	\$608,379	2,979	3,196	2,711	2,471	2,293	2,305
-----Focalin Xr	\$602,514	\$672,122	\$582,529	2,300	2,476	2,125	2,146	1,985	2,029
-----Dexmethylphenidate Hydrochloride	\$29,407	\$30,453	\$23,828	627	676	550	571	559	530
-----Focalin	\$2,025	\$1,833	\$1,349	37	38	32	35	29	31
-----Dexmethylphenidate Hydrochloride Er	\$2,983	\$1,179	\$673	15	6	4	13	6	4

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	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
Olanzapine	\$655,357	\$668,883	\$576,113	1,000	962	854	812	796	728
-----Zyprexa	\$318,943	\$469,961	\$387,495	420	614	513	354	489	422
-----Olanzapine	\$307,345	\$160,000	\$159,961	526	285	295	437	269	272
-----Zyprexa Zydis	\$29,069	\$38,922	\$28,657	54	63	46	44	40	39
Somatropin	\$614,649	\$671,963	\$556,518	158	166	140	142	136	131
-----Norditropin Flexpro Pen	\$305,970	\$295,573	\$272,907	85	84	76	73	71	73
-----Genotropin	\$88,769	\$141,705	\$85,682	17	24	13	16	18	13
-----Nutropin Aq Nuspin 10	\$68,893	\$82,512	\$64,866	21	23	19	21	17	17
-----Genotropin Miniquick	\$34,841	\$53,147	\$43,509	10	12	9	9	11	9
-----Nutropin Aq Nuspin 20	\$74,246	\$55,474	\$38,386	12	10	8	12	9	7
-----Norditropin Nordiflex Pen	\$6,040	\$6,040	\$12,079	1	1	2	1	1	2
-----Saizen	\$11,340	\$11,907	\$11,907	1	1	1	1	1	1
-----Omnitrope Pen 10 Cartridge	\$7,707	\$8,129	\$9,853	3	4	3	3	2	3
-----Nutropin Aq Pen 20 Cartridge	\$6,156	\$6,156	\$6,156	1	1	1	1	1	1
-----Omnitrope Pen 5 Cartridge	\$3,038	\$7,829	\$5,896	2	4	3	2	3	3
-----Nutropin Aq Nuspin 5	\$2,054	\$2,054	\$2,567	1	1	1	1	1	1
-----Nutropin Aq Pen 10 Cartridge	\$5,138	\$0	\$2,058	3	0	2	2	0	1
-----Humatrope	\$456	\$1,439	\$653	1	1	2	1	1	1
Omeprazole	\$627,369	\$543,759	\$490,616	9,172	7,888	7,105	7,967	7,429	6,947
-----Omeprazole	\$625,325	\$541,459	\$488,651	9,140	7,857	7,079	7,944	7,406	6,923
-----First Omeprazole	\$1,832	\$2,089	\$1,543	31	30	24	23	22	22

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	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
Ondansetron	\$668,231	\$993,971	\$466,944	6,914	9,219	4,919	6,427	7,617	4,819
-----Ondansetron Hydrochloride	\$668,231	\$993,971	\$466,281	6,914	9,219	4,918	6,427	7,617	4,818
-----Zofran Odt	\$0	\$0	\$663	0	0	1	0	0	1
Fluticasone-Salmeterol	\$554,262	\$523,367	\$463,107	1,768	1,657	1,464	1,591	1,468	1,440
-----Advair Diskus	\$486,958	\$446,561	\$399,132	1,565	1,428	1,277	1,402	1,279	1,256
-----Advair Hfa	\$67,303	\$76,806	\$63,975	203	229	187	189	191	184
Acetaminophen-Hydrocodone	\$658,721	\$553,188	\$455,591	23,832	19,310	16,765	18,920	17,109	15,603
-----Acetaminophen-Hydrocod one Bitartrate	\$658,172	\$552,940	\$455,121	23,822	19,305	16,762	18,911	17,104	15,600
Palivizumab	\$846,756	\$782,146	\$448,715	383	354	196	249	248	146
-----Synagis	\$846,756	\$782,146	\$448,715	383	354	196	249	248	146
Amoxicillin-Clavulanate	\$555,001	\$654,723	\$427,821	9,105	10,507	6,936	8,493	8,883	6,830
-----Amoxicillin-Clavulanate	\$528,569	\$627,681	\$407,964	9,067	10,469	6,908	8,461	8,852	6,804
-----Augmentin	\$23,317	\$25,028	\$18,648	33	32	26	29	27	24
-----Augmentin Xr	\$3,056	\$1,673	\$1,208	4	3	2	4	3	2
Efavirenz/Emtricitabine/ Tenofovir	\$521,875	\$481,968	\$406,073	234	215	181	200	205	175
-----Atripla	\$521,875	\$481,968	\$406,073	234	215	181	200	205	175
Insulin Aspart	\$464,392	\$475,205	\$405,358	1,115	1,113	960	984	993	921
-----Novolog	\$335,763	\$318,516	\$275,039	833	785	684	729	706	660
-----Novolog Flexpen	\$122,871	\$148,534	\$125,919	267	309	265	247	277	256
-----Novolog Penfill	\$5,758	\$8,155	\$4,401	15	19	11	14	15	11

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 Number of Claims Last Month

Generic Molecule	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
Cetirizine	\$289,250	\$323,048	\$279,497	18,098	19,453	17,169	17,137	16,312	16,924
-----Cetirizine Hydrochloride	\$286,844	\$319,991	\$276,496	17,760	19,054	16,777	16,826	15,980	16,541
-----All Day Allergy	\$1,965	\$2,427	\$2,327	299	347	340	274	289	335
-----All Day Allergy Children's	\$440	\$627	\$638	39	51	50	38	45	50
Acetaminophen-Hydrocodone	\$658,721	\$553,188	\$455,591	23,832	19,310	16,765	18,920	17,109	15,603
-----Acetaminophen-Hydrocodone Bitartrate	\$658,172	\$552,940	\$455,121	23,822	19,305	16,762	18,911	17,104	15,600
Amoxicillin	\$220,320	\$251,613	\$166,797	21,891	23,984	16,140	20,355	20,133	15,858
-----Amoxicillin	\$220,162	\$251,613	\$166,797	21,890	23,984	16,140	20,354	20,133	15,858
Albuterol	\$862,415	\$894,071	\$710,032	18,434	18,993	14,841	15,402	14,925	13,212
-----Albuterol Sulfate	\$284,225	\$311,626	\$224,164	8,601	9,394	6,802	7,845	7,757	6,567
-----Ventolin Hfa	\$273,758	\$257,318	\$213,723	5,205	4,809	4,012	4,682	4,326	3,925
-----Proventil Hfa	\$174,109	\$190,358	\$155,473	2,308	2,467	2,022	2,207	2,055	1,978
-----Proair Hfa	\$129,775	\$134,179	\$115,947	2,301	2,306	1,985	2,066	2,024	1,959
Azithromycin	\$550,650	\$666,141	\$403,277	18,546	21,694	13,246	17,213	18,129	12,949
-----Azithromycin	\$425,936	\$530,839	\$320,793	12,933	15,690	9,585	12,178	12,946	9,380
-----Azithromycin 5 Day Dose Pack	\$115,092	\$124,730	\$75,431	5,226	5,592	3,398	4,740	4,870	3,349
-----Azithromycin 3 Day Dose Pack	\$9,622	\$10,543	\$6,988	387	411	262	340	362	257
Montelukast	\$2,010,250	\$2,124,743	\$2,016,124	10,312	10,773	10,219	9,811	8,994	10,013
-----Singulair	\$1,976,538	\$2,096,714	\$1,989,674	9,997	10,506	9,972	9,509	8,758	9,768
-----Montelukast Sodium	\$33,712	\$28,029	\$26,450	315	267	247	305	236	246
Brompheniramine/ Dextromethorph/Phenylephrine	\$108,510	\$142,853	\$72,725	12,962	17,018	8,665	12,693	13,419	8,525

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 Number of Claims Last Month

Generic Molecule	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
-----Rynex Dm	\$96,207	\$126,887	\$64,278	11,531	15,108	7,642	11,308	11,926	7,530
-----Endacof-Dm	\$9,888	\$11,590	\$5,907	1,054	1,236	628	1,030	969	617
-----Dimaphen Dm	\$1,880	\$3,742	\$2,194	304	590	350	300	474	342
Lisdexamfetamine	\$1,774,219	\$1,919,541	\$1,671,481	7,900	8,387	7,328	7,470	6,841	7,055
-----Vyvanse	\$1,774,219	\$1,919,541	\$1,671,481	7,900	8,387	7,328	7,470	6,841	7,055
Omeprazole	\$627,369	\$543,759	\$490,616	9,172	7,888	7,105	7,967	7,429	6,947
-----Omeprazole	\$625,325	\$541,459	\$488,651	9,140	7,857	7,079	7,944	7,406	6,923
-----First Omeprazole	\$1,832	\$2,089	\$1,543	31	30	24	23	22	22
Ibuprofen	\$87,091	\$86,876	\$63,723	9,916	9,427	7,062	9,072	8,165	6,949
-----Ibuprofen	\$80,513	\$80,115	\$58,614	8,937	8,445	6,309	8,173	7,325	6,209
-----Ibu	\$2,481	\$2,597	\$2,055	523	517	414	465	469	411
-----Ibuprofen Children's	\$3,763	\$3,880	\$2,800	419	437	312	405	351	308
Amoxicillin-Clavulanate	\$555,001	\$654,723	\$427,821	9,105	10,507	6,936	8,493	8,883	6,830
-----Amoxicillin-Clavulanate	\$528,569	\$627,681	\$407,964	9,067	10,469	6,908	8,461	8,852	6,804
-----Augmentin	\$23,317	\$25,028	\$18,648	33	32	26	29	27	24
-----Augmentin Xr	\$3,056	\$1,673	\$1,208	4	3	2	4	3	2
Prednisolone	\$116,738	\$135,975	\$96,692	7,783	9,160	6,181	7,230	7,422	5,981
-----Prednisolone	\$52,579	\$58,739	\$41,665	4,015	4,478	3,107	3,777	3,678	3,041
-----Prednisolone Sodium Phosphate	\$56,472	\$67,835	\$45,481	3,700	4,608	3,010	3,460	3,743	2,933
-----Veripred 20	\$3,828	\$2,188	\$3,688	41	32	32	40	31	32
-----Prednisolone Sodium Phosphate Odt	\$1,378	\$2,710	\$3,735	10	18	16	9	14	16
-----Orapred Odt	\$2,057	\$4,137	\$1,949	14	21	13	14	16	13

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 Number of Claims Last Month

Generic Molecule	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
Gabapentin	\$351,145	\$301,910	\$264,111	8,047	6,967	6,131	6,764	6,428	5,841
-----Gabapentin	\$350,730	\$301,588	\$263,478	8,045	6,965	6,129	6,762	6,427	5,839
-----Gralise	\$161	\$322	\$633	1	2	2	1	1	2
Methylphenidate	\$1,367,131	\$1,397,741	\$1,242,455	6,796	6,900	6,067	5,950	5,493	5,510
-----Methylphenidate Hydrochloride Er	\$926,517	\$910,974	\$799,343	4,326	4,271	3,713	3,922	3,569	3,512
-----Methylphenidate Hydrochloride	\$13,992	\$14,833	\$12,564	816	829	724	745	688	674
-----Quillivant Xr	\$175,587	\$208,191	\$186,823	676	791	710	656	655	687
-----Metadate Cd	\$167,991	\$179,525	\$168,181	646	681	632	590	552	604
-----Daytrana	\$66,584	\$69,360	\$61,838	257	266	236	246	222	230
-----Methylin	\$9,042	\$7,653	\$8,355	27	26	24	26	20	22
-----Methylphenidate Hydrochloride Sr	\$3,299	\$2,520	\$1,503	26	15	11	25	12	11
-----Ritalin La	\$1,522	\$1,588	\$2,040	7	7	9	7	5	9
-----Concerta	\$1,399	\$2,418	\$1,445	5	8	5	4	5	5
Amphetamine-Dextroampheta mine	\$1,061,855	\$1,064,083	\$922,547	6,814	6,804	5,904	5,608	5,173	5,093
-----Adderall Xr	\$855,892	\$862,597	\$747,631	3,647	3,683	3,182	3,296	3,071	3,035
-----Amphetamine-Dextroamph etamine	\$197,596	\$194,743	\$169,916	3,114	3,081	2,693	2,757	2,531	2,493
-----Amphetamine-Dextroamph etamine Er	\$7,966	\$6,065	\$4,060	52	37	26	41	36	25
-----Adderall	\$401	\$677	\$940	1	3	3	1	3	3
Oseltamivir	\$1,848,254	\$1,884,078	\$1,015,362	10,623	10,397	5,622	10,201	8,702	5,598

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 Number of Claims Last Month

Generic Molecule	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
-----Tamiflu	\$1,848,254	\$1,884,078	\$1,015,362	10,623	10,397	5,622	10,201	8,702	5,598
Amlodipine	\$46,177	\$39,671	\$36,624	6,735	5,766	5,334	5,763	5,442	5,186
-----Amlodipine Besylate	\$46,177	\$39,671	\$36,624	6,735	5,766	5,334	5,763	5,442	5,186
Fluticasone Nasal	\$328,917	\$353,455	\$304,358	5,621	6,091	5,253	5,248	5,229	5,225
-----Fluticasone Propionate	\$322,313	\$347,229	\$298,988	5,556	6,031	5,201	5,185	5,183	5,174
-----Flonase	\$5,979	\$5,742	\$4,889	61	57	49	59	44	48
Sulfamethoxazole-Trimethoprim	\$149,101	\$141,876	\$119,355	6,330	5,835	5,113	5,812	5,103	5,028
-----Sulfamethoxazole-Trimethoprim Ds	\$32,262	\$27,795	\$25,186	3,606	3,088	2,771	3,216	2,823	2,728
-----Sulfamethoxazole-Trimethoprim	\$91,514	\$86,800	\$71,046	2,058	2,022	1,739	1,971	1,675	1,716
-----Sulfatrim Pediatric	\$25,312	\$27,272	\$23,103	664	724	601	637	613	597
Ondansetron	\$668,231	\$993,971	\$466,944	6,914	9,219	4,919	6,427	7,617	4,819
-----Ondansetron Hydrochloride	\$668,231	\$993,971	\$466,281	6,914	9,219	4,918	6,427	7,617	4,818
-----Zofran Odt	\$0	\$0	\$663	0	0	1	0	0	1
Lisinopril	\$26,394	\$23,104	\$19,707	5,819	5,037	4,613	4,992	4,730	4,497
-----Lisinopril	\$26,394	\$23,104	\$19,707	5,819	5,037	4,613	4,992	4,730	4,497
Guanfacine	\$692,513	\$747,578	\$641,195	4,688	4,942	4,320	4,339	4,069	4,100
-----Guanfacine Hydrochloride	\$328,181	\$418,001	\$371,950	3,515	3,872	3,447	3,249	3,233	3,295
-----Intuniv	\$364,332	\$329,577	\$269,245	1,173	1,070	873	1,118	852	822
Clonidine	\$177,935	\$176,117	\$167,720	4,902	4,776	4,303	4,452	4,014	4,082
-----Clonidine Hydrochloride	\$40,021	\$39,016	\$35,110	4,423	4,281	3,833	4,027	3,632	3,661
-----Clonidine Hcl	\$95,772	\$95,237	\$86,852	377	383	349	354	312	334

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 Number of Claims Last Month

Generic Molecule	Jan 2015 \$ Paid	Feb 2015 \$ Paid	Mar 2015 \$ Paid	Jan 2015 # Claims	Feb 2015 # Claims	Mar 2015 # Claims	Jan 2015 # Benes	Feb 2015 # Benes	Mar 2015 # Benes
-----Kapvay	\$28,655	\$26,660	\$28,712	65	68	72	63	54	66
-----Catapres-Tts-3	\$7,610	\$6,601	\$8,311	16	14	17	15	12	17
-----Catapres-Tts-2	\$4,015	\$5,667	\$5,664	12	16	16	11	14	16
-----Catapres-Tts-1	\$1,862	\$2,935	\$3,054	9	14	15	9	11	15
Cefdinir	\$409,501	\$535,638	\$328,689	5,237	6,618	4,143	4,946	5,495	4,085
-----Cefdinir	\$409,501	\$535,638	\$328,689	5,237	6,618	4,143	4,946	5,495	4,085
Promethazine	\$60,922	\$68,488	\$46,149	5,237	6,170	3,946	4,639	5,203	3,762
-----Promethazine Hydrochloride	\$57,106	\$64,799	\$43,722	5,103	6,007	3,827	4,545	5,085	3,683
-----Promethegan	\$3,211	\$2,892	\$2,094	90	105	93	79	87	89

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