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

MISSISSIPPI DIVISION OF
MEDICAID

August 6, 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

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
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Term Expires: June 30, 2016

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

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
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Brandon, MS 39042
Term Expires: June 30, 2017

Cherise McIntosh, Pharm.D.
UMC Dept of Pharmacy
2500 North State St.
Jackson, MS 39216
Term Expires: June 30, 2017

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

Four nominees are awaiting approval by the Governor.
Term Expires: June 30, 2018

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

August 6, 2015

Welcome Dennis Smith, R.Ph. (Chair)

Update On New DUR Board Members Judith P. Clark, R.Ph.

Old Business Dennis Smith, R.Ph. (Chair)

Approval of May 2015 Meeting Minutes page 5

Resource Utilization Review (Hardwick)

Enrollment Statistics page 11
Pharmacy Utilization Statistics page 11
Top 10 Drug by Change in Dollars Paid page 12
Top 10 Drug by Change in Number of Claims page 13

Pharmacy Program Update Judith P. Clark, R.Ph.

Introduction of new DUR Coordinator,
Sara (Cindy) Noble, Pharm.D., MPH

Feedback and Discussion from the Board

New Business

Special Analysis Projects

Summary of 2014-2015 Synagis Season (Hardwick) page 15
Patterns of Prescription Use of Triazolam (Hardwick) page 19
Methadone Use in Mississippi Medicaid Program (Banahan) page 24
Quality of Care Assurance In Use Of Antipsychotics In Children (Banahan) page 30

Next **Meeting Information** Dennis Smith, R.Ph. (Chair)

DUR Board Meeting Minutes

MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE May 7, 2015 MEETING

DUR Board Members:	Aug 2013	Nov 2013	Feb 2014	May 2014	Aug 2014	Nov 2014	Feb 2015	May 2015
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 PRESENT	**12**	**7**	**12**	**7**	**11**	**6**	**9**	**10**

Also Present:

DOM Staff:
Judith Clark, R.Ph., DOM Pharmacy Bureau Director; Terri Kirby, R.Ph., DOM Clinical Pharmacist, Donna Mills

MS-DUR Staff:
Ben Banahan, Ph.D., MS-DUR Project Director; Shannon Hardwick, R.Ph., MS-DUR Clinical Director

Xerox Staff:
Leslie Leon, Pharm.D.

MS-CAN Staff
Mr. Conor Smith

Visitors:
Phil Hecht, Abbvie; Calistra Goheen, Astra Zeneca; Brian Berhow, Sunovion; Bud McConkie , Actavis; Tim Hambacher, Otsuka; Steve Curry, Meda; Evelyn Johnson, Capital Resources; Sue Reno , DOM Program Integrity; Andrea McNeal, DOM Program Integrity

Call to Order: Mr. Dennis Smith, Chairman of the Board, called the meeting to order at 2:01 pm.

Old Business:
Dr. Hubble made a motion for approval of the minutes from the February 5, 2015 meeting. The motion was seconded by Dr. Undesser and approved unanimously.

Update on Metabolic Monitoring for Children Taking Antipsychotics
Dr. Banahan informed the board that the metabolic monitoring educational mailing initiative began in April and will continue for at least six months. After that time, MS-DUR will conduct another analysis of DOM performance on the measure and report to the board. During discussion, it was noted that the form letter needed to include information about the lab codes that would be considered as documentation of monitoring. MS-DUR will make this addition before the May mailing.

Update on Follow-up Visits for Children Starting ADHD Medications
Dr. Banahan informed the board that the ADHD follow-up care educational mailing initiative began May 1 and will continue for at least six months. After that time, MS-DUR will conduct another analysis of DOM performance on the measure and report to the board.

Resource Utilization Review:
Ms. Hardwick reviewed the enrollment data and resource utilization tables. The most significant changes in products based on number of prescriptions and amount paid were attributed to seasonal fluctuations and a new product coming on the market. A large percentage increase in payments for Filgrastim was noted that was not associated with an increase in beneficiaries or prescriptions. MS-DUR is looking into this increase. Ms. Clark asked that MS-DUR drill down into the increase in epinephrine use.

Pharmacy Program Update:
Ms. Clark reminded the board that the UPDL went into effect January 1 and coordinated care is required to follow UPDL and criteria included. Providers are encouraged to get in touch with DOM for any pharmacy related PA problems related to UPDL. MS-DUR and the DUR Board will be responsible for identifying and helping address any pharmacy issues affecting DOM beneficiaries regardless of pharmacy program they are enrolled in. Four board members' terms expire this year. Process is DOM Pharmacy Bureau submits recommendations to DOM Executive and their recommendations are forwarded to Governor's office. Final selection and appointment is made by Governor's office. Ms. Clark reported that some prescribers are reporting problems with products with very limited distribution channel and niche market.

Feedback and Discussion from the Board

Mr. Smith informed board about issue that occurs occasionally with patients having primary with private insurance and secondary with Medicaid. When filing with Medicaid for co-pay sometimes co-pay claims are rejected because of preferred status issues. The Medicaid fee-for-service point of sale program allows for a primary payer to pay for a portion of the claim and Medicaid act as a secondary payer. MSCAN, or coordinated care plans participating in MS Medicaid, are to follow the same processes. Mr. Conor Smith, Magnolia's pharmacy director, reported that since Magnolia's PA process is not automated, pharmacies will need to call for approval. Ms. Clark indicated DOM will work with all payers to try and resolve the issue but stated it is very complex when multiple payers are involved in a claim. In response to question, Ms. Clark clarified that by Federal law Medicaid is payer of last resort. Pharmacy claims must be submitted to the primary insurer every time prior to submitting to Medicaid, including fee for service or coordinated care.

New Business:

Clinical Guidelines for Hysingla
Ms. Hardwick reviewed background about the recent FDA approval of Hysingla and MS-DUR proposed clinical criteria. She noted that the P&T Committee will meet the next week and it is being recommended that Hysingla be listed as a non-preferred product. The clinical criteria recommended by MS-DUR for inclusion in the UPDL were:

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

After discussion, Dr. Undesser made a motion to approve the recommended criteria. The motion was seconded by Dr. Hubble and passed unanimously.

Ms. Clark called the board's attention to the handout in their folders of the recent *Most States list Deadly Methadone as a 'Preferred Drug'* report from The Pew Charitable Trusts. The report is regarding methadone being a preferred drug in several state Medicaid programs, including Mississippi. She shared results from an MS-DUR analysis of methadone use in 2014 and 2015 and noted utilization is trending up. Ms. Clark asked for recommendation from DUR Board that the P&T Committee review methadone status on the UPDL. Dr. Cox made motion to send methadone review to P&T committee. The motion was seconded by Dr. Parham and passed unanimously. Dr. Banahan noted that MS-DUR will provide the P&T Committee a summary of utilization numbers in 2014 and 2015 for use during their considerations.

Overview of Uniform Preferred Drug List
Dr. Banahan provided an overview of the information that will be included in UPDL Compliance Report that will be provided to DOM each month and how the information will be used to assure appropriate use of non-preferred products and consistent implementation of the UPDL across the three programs. Ms. Clark noted that MS-DUR and the DUR Board will be responsible for monitoring prescription drug utilization for all Medicaid including FFS and coordinated care and that the Pharmacy Bureau will be working closely with the coordinated care plans to assure consistency.

Concomitant Use of Naltrexone and Bupropion for Weight Control
Dr. Banahan reviewed the MS-DUR analysis showing an increase in concomitant use of naltrexone and bupropion. During the discussion, MS-DUR was asked to examine whether the prescribers involved were associated with weight loss clinics. MS-DUR made the following recommendation:

- DOM and the coordinated care plans should implement a clinical edit that would prevent concomitant use of naltrexone and bupropion without manual prior authorization and documentation of medical necessity.

Dr. Hubble made a motion to accept the recommendation and it was seconded by Dr. Parham. The motion passed unanimously.

Evaluation of Potential Criteria for Use of Multiple Hypoglycemic Agents
Dr. Banahan provided an overview of the MS-DUR report on potential criteria for the use of multiple hypoglycemic agents and regimens currently being used to treat DOM beneficiaries. The following guidelines had been proposed by Gould Health Services:

- 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 prior authorization (PA):
    - Sulfonylureas + insulin
    - Sulfononylureas + meglitinides
    - DPP-4 Inhibitors + GLP-1 Agonist
- Use of combination products count as two agents (i.e. Janumet contains sitagliptin and metformin 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 is 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 (≤ 1mg/dL).
- Use of an SGLT-2 Inhibitor would be considered if the patient could not take insulin.
- Approved PAs for a 4th agent requiring reevaluation every 6 months with updated A1C values for proof that the regimen of 4 agents is yielding positive outcomes/results

The Board concurred with the recommended guidelines and Dr. McIntosh asked that avoiding use of duplicate insulin products be added to the list. After discussion, the board made the following recommendations:

- MS-DUR should work with experts in the area to develop educational article(s) for publication in the appropriate state professional journals.
- MS-DUR should initiate an educational intervention mailing to notify prescribers of patients whose treatment is not in compliance with these guidelines.

Overview of Office of Inspector General Report on 2nd Generation Antipsychotics and Children
Dr. Banahan provided an overview of the recent Office of the Inspector General report and the summary handout provided to the board. He informed the board that a comprehensive review of quality-of-care criteria related to the use of antipsychotics in children will be done at the August board meeting. Ms. Clark stressed the importance of this issue and the increasing attention it is receiving from CMS.

Exceptions Monitoring
Dr. Banahan noted that the three recommended exceptions are from FDA notices. Dr. Davis made motion to accept recommendations. The motion was seconded by Dr. Hubble and approved unanimously.

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 3:31 pm.

Submitted,
Evidence-Based DUR Initiative, MS-DUR

Resource Utilizaton Review

ENROLLMENT STATISTICS FOR LAST 6 MONTHS January 2015 through June 2015							
			Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Total enrollment			760,941	761,413	759,745	757,588	750,439	737,585
Dual-eligibles			154,680	154,592	154,343	154,203	153,793	153,420
Pharmacy benefits			659,432	659,394	657,477	654,853	647,177	634,069
	LTC		17,628	17,495	17,507	17,321	16,926	16,537
	PLAN %	FFS	71.6%	71.2%	68.8%	68.2%	50.7%	32.9%
		MSCAN-UHC	13.5%	13.7%	15.0%	15.3%	23.9%	33.1%
		MSCAN-Magnolia	14.9%	15.1%	16.2%	16.5%	25.4%	34.0%

PHARMACY UTILIZATION STATISTICS FOR LAST 6 MONTHS January 2015 through June 2015							
		Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
# Rx Fills	FFS	281,168	332,827	251,463	280,703	156,144	--
	MSCAN-UHC	125,763	117,352	130,459	--	--	--
	MSCAN-Mag	212,007	151,637	165,247	169,024	--	--
# Rx Fills / Bene	FFS	0.6	0.7	0.6	0.6	0.5	--
	MSCAN-UHC	1.4	1.3	1.3	--	--	--
	MSCAN-Mag	2.2	1.5	1.6	1.6	--	--
$ Paid Rx	FFS	$25,406,359	$29,977,818	$25,387,227	$26,947,781	$17,752,231	--
	MSCAN-UHC	$10,118,159	$10,202,031	$11,126,598	$6,647,789	--	--
	MSCAN-Mag	$16,584,196	$12,399,355	$13,383,253	$14,400,690	--	--
$ /Rx Fill	FFS	$90.36	$90.07	$100.96	$96.00	$113.69	--
	MSCAN-UHC	$80.45	$86.94	$85.29	--	--	--
	MSCAN-Mag	$78.22	$81.77	$80.99	$85.20	--	--
$ /Bene	FFS	$53.81	$63.85	$56.12	$60.34	$54.10	--
	MSCAN-UHC	$113.66	$112.93	$112.82	--	--	--
	MSCAN-Mag	$168.79	$124.53	$125.65	$133.28	--	--

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

-- Indicates cells with incomplete data due to a change in the format of the data files received by MS-DUR beginning in June.

TOP 10 CATEGORIES BY DOLLARS PAID April Through June 2015 Medicaid Fee-For-Service Only					
Category		**Rank Paid Amt**	**# RXs**	**$ Paid**	**# Benes**
ANTIPSYCHOTICS	Apr-15	3	6,518	$2,479,947	4,352
	May-15	2	4,549	$1,793,894	3,304
	Jun-15				
CENTRAL NERVOUS SYSTEM AGENTS	Apr-15	1	21,205	$4,517,492	15,261
	May-15	1	11,425	$2,445,112	9,474
	Jun-15				
ANTIVIRAL AGENTS	Apr-15	10	1,211	$843,612	931
	May-15	9	616	$599,988	443
	Jun-15				
ANTICONVULSANTS	Apr-15	4	10,423	$1,274,245	6,186
	May-15	5	7,985	$959,258	5,197
	Jun-15				
COAGULATION MODIFIERS	Apr-15	6	52	$1,116,529	34
	May-15	3	51	$1,564,380	42
	Jun-15				
RESPIRATORY AGENTS	Apr-15	2	50,435	$2,861,163	33,425
	May-15	4	23,050	$1,504,656	17,923
	Jun-15				
ANTIDIABETIC AGENTS	Apr-15	9	3,883	$860,018	2,179
	May-15	6	3,037	$678,297	1,831
	Jun-15				
CARDIOVASCULAR AGENTS	Apr-15	8	12,048	$971,201	8,536
	May-15	8	8,538	$630,902	6,468
	Jun-15				
BRONCHODILATORS	Apr-15	5	12,760	$1,205,846	8,520
	May-15	7	6,153	$660,453	4,661
	Jun-15				
ANTINEOPLASTICS	Apr-15	13	2,853	$672,416	2,352
	May-15	14	1,496	$364,486	1,366
	Jun-15				

NOTE: June figures are not reported due to change in format of data files received by MS-DUR.

TOP 10 CATEGORIES BY NUMBER OF CLAIMS April Through June 2015 Medicaid Fee-For-Service Only					
Category	**Month Year**	**Rank Volume**	**# RXs**	**$ Paid**	**# Benes**
RESPIRATORY AGENTS	Apr-15	1	50,435	$2,861,163	33,425
	May-15	1	23,050	$1,504,656	17,923
	Jun-15				
ANTICONVULSANTS	Apr-15	8	10,423	$1,274,245	6,186
	May-15	7	7,985	$959,258	5,197
	Jun-15				
CARDIOVASCULAR AGENTS	Apr-15	7	12,048	$971,201	8,536
	May-15	5	8,538	$630,902	6,468
	Jun-15				
ANALGESICS	Apr-15	4	17,044	$438,285	12,130
	May-15	3	9,382	$290,045	7,420
	Jun-15				
CENTRAL NERVOUS SYSTEM AGENTS	Apr-15	2	21,205	$4,517,492	15,261
	May-15	2	11,425	$2,445,112	9,474
	Jun-15				
DERMATOLOGICAL AGENTS	Apr-15	5	16,692	$1,003,358	11,645
	May-15	4	8,806	$486,011	7,158
	Jun-15				
GASTROINTESTINAL AGENTS	Apr-15	11	8,858	$738,804	6,342
	May-15	9	5,449	$520,970	4,359
	Jun-15				
ANTIDEPRESSANTS	Apr-15	14	6,778	$196,772	4,869
	May-15	10	4,852	$158,750	3,795
	Jun-15				
ANTIPSYCHOTICS	Apr-15	16	6,518	$2,479,947	4,352
	May-15	12	4,549	$1,793,894	3,304
	Jun-15				
NUTRITIONAL PRODUCTS	Apr-15	15	6,645	$107,641	4,779
	May-15	13	4,317	$59,006	3,546
	Jun-15				

NOTE: June figures are not reported due to change in format of data files received by MS-DUR.

New Business

Special Analysis Projects

SYNAGIS UTILIZATION SUMMARY – 2014-15 SEASON

Version 07/17/2015

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 were presented to the board and the board voted to adopt them as the criteria to be used by DOM for the 2014-15 Season.

PALIVIZUMAB 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 39% 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 pharmacy program. The overall change in dollars paid for Synagis treatment this season for FFS is -55% compared to an average of -36% for the coordinated care programs. Although no large shift in beneficiaries occurred during these two seasons, some of the difference between the FFS program and the coordinated care programs may be due to changes in beneficiary enrollment.

[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 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	$191,580	
	November	$507,819	$955,354	$430,753	
	December	$1,031,228	$1,150,556	$775,777	
	January	$1,106,160	$1,364,114	$847,897	
	February	$967,528	$1,264,227	$778,417	
	March	$875,716	$830,245	$515,609	
	TOTAL	**$5,120,155**	**$5,840,759**	**$3,540,033**	**-39.4%**
FFS	October	$494,537	$78,878	$49,171	
	November	$396,751	$164,728	$82,260	
	December	$394,775	$211,316	$129,270	
	January	$302,133	$259,775	$105,752	
	February	$280,615	$270,268	$119,391	
	March	$201,792	$203,639	$54,941	
	TOTAL	**$2,070,603**	**$1,188,604**	**$540,785**	**-54.5%**
Magnolia	October	$69,748	$174,957	$133,191	
	November	$59,995	$327,292	$123,136	
	December	$359,676	$463,160	$355,491	
	January	$463,638	$530,448	$445,054	
	February	$379,060	$463,626	$339,502	
	March	$412,433	$224,906	$247,594	
	TOTAL	**$1,744,550**	**$2,184,389**	**$1,643,967**	**-24.7%**
UHC	October	$51,257	$19,818	$3,995	
	November	$49,787	$455,501	$208,312	
	December	$263,470	$461,660	$277,965	
	January	$318,195	$562,765	$287,875	
	February	$295,355	$512,056	$312,919	
	March	$246,996	$392,501	$213,074	
	TOTAL	**$1,225,060**	**$2,404,302**	**$1,304,140**	**-45.8%**

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 42% decrease in the number of beneficiaries treated. 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 pharmacy program. The overall change in the number of beneficiaries treated this season for FFS is -52% compared to an average of -39% for the coordinated care programs. Again, some of the difference between the FFS and coordinated care programs may be due to changes in overall program enrollment.

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	70	
	November	207	346	164	
	December	362	387	232	
	January	378	421	250	
	February	360	425	248	
	March	303	287	173	
	TOTAL Bene-Months	**1,856**	**1,961**	**1,137**	**-42.0%**
FFS	October	198	26	19	
	November	172	74	38	
	December	131	78	43	
	January	116	79	36	
	February	117	87	40	
	March	69	77	26	
	TOTAL Bene-Months	**803**	**421**	**202**	**-52.0%**
Magnolia	October	25	60	47	
	November	21	116	42	
	December	129	155	101	
	January	146	165	114	
	February	130	155	102	
	March	135	77	77	
	TOTAL Bene-Months	**586**	**728**	**483**	**-33.7%**
UHC	October	17	8	2	
	November	13	153	80	
	December	96	147	84	
	January	107	172	97	
	February	108	177	104	
	March	92	128	70	
	TOTAL Bene-Months	**433**	**785**	**437**	**-44.3%**

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 or to drop slightly based on the new guidelines resulting in younger/smaller infants being treated with lower doses that would offset price increases by the manufacturer. Overall, the average payment per beneficiary treated increased only 4.5%. Again, this varied by pharmacy program. The overall change in payments/beneficiary treated this season for FFS is -5.2% compared to an average of +5% for the coordinated care programs.

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	$2,736.85	
	November	$2,453.23	$2,761.14	$2,626.54	
	December	$2,848.70	$2,973.01	$3,343.86	
	January	$2,926.35	$3,240.18	$3,391.59	
	February	$2,687.58	$2,974.65	$3,138.78	
	March	$2,890.15	$2,892.84	$2,980.40	
	Season Avr.	**$2,758.70**	**$2,978.46**	**$3,113.49**	**4.5%**
FFS	October	$2,497.66	$3,033.78	$2,587.95	
	November	$2,306.69	$2,226.05	$2,164.74	
	December	$3,013.55	$2,709.18	$3,006.28	
	January	$2,604.60	$3,288.29	$2,937.54	
	February	$2,398.42	$3,106.53	$2,984.77	
	March	$2,924.53	$2,644.66	$2,113.12	
	Season Avr.	**$2,578.58**	**$2,823.29**	**$2,677.15**	**-5.2%**
Magnolia	October	$2,789.93	$2,915.95	$2,833.86	
	November	$2,856.89	$2,821.49	$2,931.81	
	December	$2,788.19	$2,988.13	$3,519.71	
	January	$3,175.60	$3,214.83	$3,903.98	
	February	$2,915.84	$2,991.14	$3,328.45	
	March	$3,055.06	$2,920.86	$3,215.50	
	Season Avr.	**$2,977.05**	**$3,000.53**	**$3,403.66**	**13.4%**
UHC	October	$3,015.15	$2,477.31	$1,997.66	
	November	$3,829.77	$2,977.13	$2,603.90	
	December	$2,744.48	$3,140.54	$3,309.11	
	January	$2,973.78	$3,271.89	$2,967.78	
	February	$2,734.77	$2,892.97	$3,008.83	
	March	$2,684.74	$3,066.42	$3,043.92	
	Season Avr.	**$2,829.24**	**$3,062.80**	**$2,984.30**	**-2.6%**

Overall, the changes in utilization and cost for Synagis this season are in line with expectations based on the change in the treatment guidelines. MS-DUR is working on an analysis of changes in rates for pneumonia and bronchitis due to respiratory syncytial virus (RSV) in the target population.

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

PATTERNS OF PRESCRIPTION USE OF TRIAZOLAM

Version July 17, 2015

BACKGROUND

Triazolam is an oral benzodiazepine. It is used as a sedative-hypnotic agent in treating severe short-term insomnia which generally lasts 7 to 10 days. Guidance on usage and length of therapy from the prescribing information include:

Indications and Usage for Triazolam

Triazolam Tablets USP, are indicated for the short-term treatment of insomnia (generally 7 to 10 days). Use for more than 2 to 3 weeks requires complete reevaluation of the patient (see WARNINGS).

Prescriptions for Triazolam should be written for short-term use (7 to 10 days) and it should not be prescribed in quantities exceeding a 1-month supply.

Warnings

Because sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. **The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated.** Worsening of insomnia or the emergence of new thinking or behavior abnormalities may be the consequence of an unrecognized psychiatric or physical disorder. Such findings have emerged during the course of treatment with sedative-hypnotic drugs. Because some of the important adverse effects of sedative-hypnotics appear to be dose related (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), it is important to use the smallest possible effective dose, especially in the elderly.

In the post discussion following the May 12, 2015 Medicaid P&T Committee meeting, MS-DUR was asked to run an analysis to:

- determine how many beneficiaries are using Triazolam
- evaluate whether prescribers were following the recommended duration of therapy.

METHODS

A retrospective analysis was conducted using Mississippi Medicaid fee-for-service (FFS) and managed care pharmacy claims data for the period January 1, 2014 through December 31, 2014. Triazolam was identified using NDC codes in the pharmacy data. Beneficiaries using Triazolam were tracked to identify their prescribers and prescribing patterns.

RESULTS

A total of 320 unique beneficiaries were identified as having been prescribed Triazolam in 2014. The majority of these beneficiaries were female with considerable variation in age. Table 1 shows the characteristics of Triazolam users by Medicaid pharmacy program. 6.6% of Triazolam users had prescriptions from more than one provider. Almost one-fourth of Triazolam users had more than one prescription filled during the year. The average days supply per prescription fill was 4.8 days in the FFS program and 10.5 days in the UHC program. This average indicates that most prescribing is within the recommended 7-10 days of treatment. The average prescription fill in the Magnolia program, however, was 16.3 days, indicating that beneficiaries in this program may be receiving longer treatment than is recommended.

No maximum length of therapy is indicated in the prescribing information. However, the warning indicates that if 7-10 days of therapy is not sufficient, patients should be reevaluated for an underlying psychiatric or mental health condition that should be addressed rather than continuing treatment with Triazolam. The average total days of therapy for beneficiaries in the FFS program was 11.1 days. This indicates that most patients were only treated for a short period of time. However, the average total days of therapy for beneficiaries in the Magnolia and UHC programs were 64.9 and 51, respectively. These figures greatly exceed the recommended 7-10 days and the warning of exceeding a one-month supply.

TABLE 1: Beneficiary Characteristics and Triazolam Use by Pharmacy Program (January - December 2014)

		Pharmacy Program			
		FFS	Magnolia	UHC	TOTAL
Total		181	66	73	320
Gender	F	122 67.4%	53 80.3%	52 71.2%	227 70.9%
	M	59 32.6%	13 19.7%	21 28.8%	93 29.1%
Age (as of 12/31/2014)	<=15	55 30.4%	3 4.6%	3 4.1%	61 19.1%
	16 - 20	76 42.0%	6 9.1%	6 8.2%	88 27.5%
	21 - 35	17 9.4%	29 43.9%	24 32.9%	70 21.9%
	36 - 45	7 3.9%	12 18.2%	15 20.6%	34 10.6%
	46+	26 14.4%	16 24.2%	25 34.3%	67 20.9%
# of different prescribers	1	176 97.2%	57 86.4%	66 90.4%	299 93.4%
	2	4 2.2%	7 10.6%	7 9.6%	18 5.6%
	3	1 0.6%	2 3.0%	0 0.0%	3 0.9%
# of RX fills	1	153 84.5%	46 69.7%	46 63.0%	245 76.6%
	2	15 8.3%	8 12.1%	6 8.2%	29 9.1%
	3	5 2.8%	0 0.0%	2 2.7%	7 2.2%
	4	2 1.1%	0 0.0%	4 5.5%	6 1.9%
	5+	6 3.3%	12 18.2%	15 20.6%	33 10.3%
Average days supply/ fill		4.8	16.3	10.5	8.6
Average days total supply		11.1	64.9	51	31.6

Note: Beneficiaries are attributed to last pharmacy program enrolled in.

A total of 120 prescribers were associated with these prescriptions for Triazolam. Table 2 shows the number of each type of provider and the average prescribing pattern for each type.

TABLE 2: Triazolam Prescribing Characteristics by Type of Prescriber
(January - December 2014)

Type of Prescriber	# of Prescribers	Total # Beneficiaries	Average # Beneficiaries/ Prescriber	Total # of Fills	Average # of Fills/ prescriber	Average # of Fills/ Beneficiary	Average Days Supply/ Fill	Average Total Days Supply/ Beneficiary
DDO-Dentist	19	211	11.1	227	11.9	1.1	2	2
MD-Cardiologist	1	1	1.0	1	1.0	1.0	30	30
MD-Emergency Med	2	2	1.0	2	1.0	1.0	19	19
MD-Family Practice	27	40	1.5	123	4.6	3.4	25	94
MD-General Practice	2	2	1.0	5	2.5	2.5	30	75
MD-Gastroenterology	1	1	1.0	4	4.0	4.0	30	120
MD-Hematology/Onc	1	1	1.0	1	1.0	1.0	30	30
MD-Internal Medicine	7	9	1.3	29	4.1	3.6	30	107
MD-Neurology	4	7	1.8	18	4.5	1.7	29	46
MD-OB/GYN	4	10	2.5	10	2.5	1.0	24	24
MD-Opthalmologist	1	1	1.0	1	1.0	1.0	10	10
MD-Orthopedist	1	1	1.0	1	1.0	1.0	2	2
MD-Other	1	2	2.0	11	11.0	5.5	30	165
MD-Pain	3	7	2.3	27	9.0	2.7	20	70
MD-Pediatrics	2	3	1.5	5	2.5	1.5	1	2
MD-Psychiatrist	3	5	1.7	13	4.3	2.3	24	58
MD-Surgeon	2	2	1.0	4	2.0	2.0	16	46
NP	3	3	1.0	11	3.7	3.7	20	100
NP-Family Practice	20	27	1.4	68	3.4	2.4	26	65
NP-Mental Health	3	6	2.0	30	10.0	5.4	30	164
Podiatrist	1	1	1.0	1	1.0	1.0	1	1
Other Provider	1	1	1.0	6	6.0	6.0	15	90

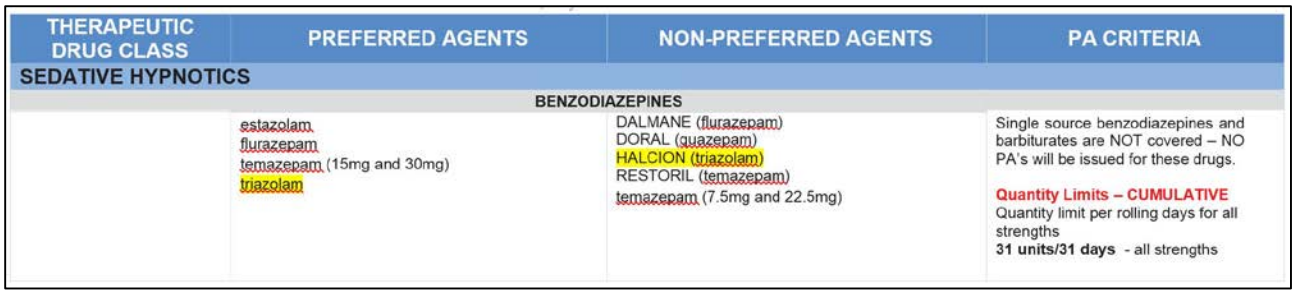
MS-DUR contacted the pharmacies filling Triazolam prescriptions written by gastroenterologist and podiatrist to confirm NPIs are correct. The pharmacist reported that the gastroenterologist sees this patient every couple of weeks and the pharmacist is aware of the unusual nature of this prescribing. The pharmacy confirmed the prescription by the provider identified as being a podiatrist. This was a single prescription for one dose to be taken the night before a procedure.

Examples of clinical criteria utilized by other state Medicaid agencies for Triazolam include the following.

State	Status / Clinical Criteria / Limits
Alabama	Class is not reviewed for PDL
Florida	Class is not reviewed for PDL
Georgia	Triazolam and Halcion non-preferred
Louisiana	Triazolam generic preferred product
Maine	Triazolam generic preferred product Maximum quantity 10/month for all benzodiazepines
New York	Triazolam and Halcion non-preferred product First fill limited to 10 day supply 30 day duration limit (no time period specified)
Nevada	Triazolam generic preferred product
Tennessee	Triazolam and Halcion non-preferred products 14 / 30 days
Wisconsin	Triazolam generic preferred product

CONCLUSIONS

Currently in the UPDL, Triazolam (generic) is a preferred product and Halcion (brand) is a non-preferred product. The benzodiazepine class has a quantity limit of 31 units per 31 days (a dosing limit) but no cumulative quantity limit over time.



THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SEDATIVE HYPNOTICS			
BENZODIAZEPINES			
	estazolam flurazepam temazepam (15mg and 30mg) triazolam	DALMANE (flurazepam) DORAL (quazepam) HALCION (triazolam) RESTORIL (temazepam) temazepam (7.5mg and 22.5mg)	Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs. **Quantity Limits – CUMULATIVE** Quantity limit per rolling days for all strengths **31 units/31 days** - all strengths

Based on the average number of fills/beneficiary, the average days supply/fill and the average total days supply/beneficiary it appears that many prescribers seem to be unaware of the therapy recommendations for Triazolam and may be using the drug longer than recommended.

Triazolam is available in bottles of 500 and bottles/strips of 10.

RECOMMENDATIONS

Based on these findings, MS-DUR makes the following recommendations:

1. The DUR Board recommend to the P&T Committee that Triazolam be changed to non-preferred unless there are supplemental contract requirements preventing this change.

2. MS-DUR initiate an educational intervention with prescribers exceeding the following treatment guidelines:
    a. Beneficiaries having more than 2 Triazolam fills in a year that exceed a total of 30 days supply
    b. Beneficiaries having 2 or more prescriptions for >15 days supply

3. DOM implement the following clinical edits to assure more appropriate use of Triazolam:
    a. Quantity limit of 10 day supply per month
    b. Cumulative quantity limit of 60 days within a 365 day period

METHADONE USE IN MISSISSIPPI MEDICAID PROGRAM

Version 07/17/2015

BACKGROUND

April 23, 2015, the Pew Charitable Trust released a report titled, "Most States List Deadly Methadone as a Preferred Drug". In the report, the following comments were made about the use of methadone.

> Methadone overdoses kill about 5,000 people every year, six times as many as in the late 1990s, when it was prescribed almost exclusively for use in hospitals and addiction clinics where it is tightly controlled. It is four times as likely to cause an overdose death as oxycodone, and more than twice as likely as morphine. In addition, experts say it is the most addictive of all opiates. Yet as many as 33 states make it easy for doctors to prescribe the pain medicine to Medicaid patients, no questions asked. In those states, methadone is listed as a "preferred drug," meaning Medicaid will cover its costs without any red tape. If a drug is not on a preferred list, doctors must explain why they are prescribing it before the prescription can be filled and paid for by Medicaid.
>
> In 2013, North Carolina became the first state to remove methadone from its preferred drug list, according to research by the Academy of Pain Medicine. The District of Columbia and at least 16 other states took similar actions. Arkansas, Georgia, Kansas, Minnesota, Missouri, Montana, Nevada, New Hampshire, New York, Oregon, Rhode Island, South Carolina, Tennessee, Texas, West Virginia and Wyoming no longer list methadone as a preferred long-acting analgesic.
>
> Washington state, which has the third-highest methadone death rate in the country after Maine and Utah, decided not to take the pain medicine off its preferred list. The committee decided "it was not the drug's problem, it was the prescribers' problem," said Dr. Charissa Fotinos, deputy chief medical officer for the Washington State Health Care Authority, which administers Medicaid. Instead, the committee decided to write warning letters to the top 20 prescribers of the drug and visit their offices to educate them on the long-acting opiate's tricky pharmacology.

During the May 7, 2015 meeting of the Division of Medicaid (DOM) Drug Utilization Review (DUR) Board the Pew Report was shared with the board. A motion was made and passed unanimously that the MS-DUR provide information about use of methadone during the last year and present the information to the Board for review of methadone utilization and to determine if any changes are needed.

METHODS

A retrospective analysis was conducted using Mississippi Medicaid fee-for-service and coordinated care pharmacy claims for the period January 2014 through March 2015. All methadone claims were extracted and pharmacies and prescribers were identified.

RESULTS

Table 1 shows the number of beneficiaries receiving methadone prescriptions and the total number of methadone prescriptions for each Medicaid pharmacy program for 2014 and the first three months of 2015. If the first three months of 2015 are representative of the actual trend in use for the year, Medicaid will see an overall increase of 47% in methadone prescriptions. There are significant differences among the pharmacy plans with respect to average number of methadone prescriptions per beneficiary and in the projected increase in methadone use. Projected increases in use were 20% for FFS, 84% for Magnolia, and 34% for UHC.

TABLE 1: Number of Beneficiaries and Prescription Claims by Pharmacy Program (January 2014 - March 2015)

	FFS			Magnolia			United Health Care			TOTAL MEDICAID		
	Unique Benes	# RX Claims	Claims / Bene	Unique Benes	# RX Claims	Claims / Bene	Unique Benes	# RX Claims	Claims / Bene	Unique Benes	# RX Claims	Claims / Bene
2014	96	287	3.0	63	435	6.9	154	619	4.0	313	1341	4.3
Q1 2015	46	86		87	200		87	207		220	493	
Est. 2015		344			800			828			1972	

Table 2 shows the number of beneficiaries being prescribed methadone by the type of prescriber. Based on NPI data, 23 MDs were identified as specializing in pain management (MD-Pain), 1 of the MD-IMs was identified as working in addiction and 3 other MDs were identified as working in pain although it was not their major area of specialization. 6 of these prescribers were identified as having practice addresses at UMMC. None of these prescribers had practice addresses that would indicate affiliation with a methadone clinic in Jackson or the surrounding states.

TABLE 2: Number of Benerficiaries and Pharmacy Claims by Provider Type (January 2014 - March 2015)			
Provider Type	# Prescribers	# Benes	# RX Claims
MD-Anesth	20	59	154
MD-Card	2	2	14
MD-EM	2	2	2
MD-FP	27	56	284
MD-GP	1	1	1
MD-Gastro	2	3	4
MD-Hem/Onc	10	22	39
MD-Hospit	1	1	1
MD-ID	1	1	8
MD-IM	19	30	116
MD-Neur	4	40	203
MD-OB/GYN	2	3	3
MD-Other	6	8	33
MD-Pain	23	97	289
MD-Ped	17	19	35
MD-Psych	1	1	1
MD-Surg	1	1	1
NP	11	49	157
NP-FM	28	113	384
NP-Ped	1	1	1
PA	3	10	33
Prov-Other	11	19	60

Table 3 shows the number of methadone prescriptions filled by city. NOTE: some cities have been combined as metropolitan areas. The greatest number of methadone prescription fills occurred along the coast and in the delta:

- 245 - Gulfport / Biloxi / D'Iberville / Ocean Springs area
- 230 – Greenville / Leland area
- 181 – Moss Point / Pascagoula / Gautier area
- 123 – Meridian

The only methadone clinic in Mississippi is located in Jackson. However, the Jackson / Byram / Clinton area only had 46 methadone prescription fills. Based on the provider types, it appears that most methadone use in Mississippi is for pain management and not for drug abuse.

TABLE 3: Number of Claims for Methadone by City of Pharmacy Where FIlled (January 2014 - March 2015)			
Pharmacy City	**Number of Claims**	**Pharmacy City**	**Number of Claims**
AL - RED BAY	1	MS - LIBERTY	6
MS - AMORY	1	MS - LUCEDALE	56
MS - BALDWYN	3	MS - MAGNOLIA	6
MS - BATESVILLE	4	MS - MCCOMB	90
MS - BEAUMONT	2	MS - MENDENHALL	17
MS - BELZONI	4	MS - MERIDIAN	123
MS - BILOXI / GULFPORT / D'IBERVILLE / OCEAN SPRINGS	245	MS - MONTICELLO	2
MS - BOONEVILLE	1	MS - MOSS POINT / PASCAGOULA / GAUTIER	181
MS - BRANDON / PEARL	48	MS - NETTLETON	5
MS - BROOKHAVEN	28	MS - OXFORD	4
MS - CALEDONIA	1	MS - PASS CHRISTIAN / WAVELAND	14
MS - CLARKSDALE	14	MS - PETAL	27
MS - CLEVELAND	13	MS - PICAYUNE	22
MS - COLLINSVILLE	1	MS - PONTOTOC	19
MS - COLUMBIA	45	MS - POPLARVILLE	17
MS - COLUMBUS	14	MS - PRENTISS	3
MS - CORINTH	8	MS - PURVIS	2
MS - DECATUR	1	MS - QUITMAN	34
MS - DIBERVILLE	12	MS - RICHTON	3
MS - ELLISVILLE	30	MS - RIDGELAND	13
MS - ENTERPRISE	14	MS - RIPLEY	4
MS - EUPORA	1	MS - RULEVILLE	15
MS - FLORA	3	MS - SEMINARY	2
MS - FLOWOOD	15	MS - SENATOBIA / COLDWATER	8
MS - FULTON	4	MS - SHELBY	1
MS - GREENVILLE / LELAND	230	MS - STARKVILLE	15
MS - GREENWOOD	60	MS - TERRY	3
MS - GRENADA	17	MS - TUNICA	3
MS - HATTIESBURG	67	MS - TUPELO / SALTILLO	21
MS - HERNANDO	1	MS - TYLERTOWN	4
MS - HOLLY SPRINGS	1	MS - UNION	5
MS - HORN LAKE / OLIVE BRANCH / SOUTHAVEN	26	MS - VANCLEAVE	27
MS - INDIANOLA	9	MS - VICKSBURG	6
MS - IUKA	3	MS - WAYNESBORO	3
MS - JACKSON / BYRAM / CLINTON	46	MS - WEST POINT	5
MS - KILN	16	MS - WIGGINS	20
MS - LAUREL	23	MS - WINONA	5
MS - LEAKESVILLE	3	TN - MEMPHIS	26

Table 4 shows the number of methadone prescriptions written by city of the prescriber. NOTE: some cities have been combined as metropolitan areas. The greatest number of methadone prescriptions were written by prescribers on the coast and in the delta. Meridian was the only other city with a high number of prescriptions written and filled. Jackson and Hattiesburg had a high number of prescriptions written even though they were not exceptionally high on the number of prescriptions filled.

- 460 - Gulfport / Biloxi / D'Iberville / Ocean Springs area
- 253 – Greenville
- 173 – Jackson
- 123 – Hattiesburg
- 117 – Meridian

The distribution of where methadone prescriptions are written and where they are filled indicates that beneficiaries are traveling to see physicians who write methadone prescriptions.

TABLE 4: Number of Claims for Methadone by City of Prescriber Writing Prescription (January 2014 - March 2015)

Prescriber City	Number of Claims	Prescriber City	Number of Claims
AL - BIRMINGHAM	9	MS - HATTIESBURG	123
AL - HUNTSVILLE	1	MS - INDIANOLA	1
AL - MOBILE	24	MS - IUKA	2
AL - TUSCALOOSA	1	MS - JACKSON	173
AR - LAKE VILLAGE	1	MS - LAUREL	57
LA - BAKER	12	MS - LUCEDALE	1
LA - SLIDELL	7	MS - MCCOMB	100
MS - BATESVILLE	9	MS - MENDENHALL	3
MS - BENTON	3	MS - MERIDIAN	117
MS - BILOXI / GULFPORT / D'IBERVILLE / OCEAN SPRINGS	460	MS - MOSS POINT / PASCAGOULA	87
MS - BOONEVILLE	3	MS - OXFORD	5
MS - BROOKHAVEN	8	MS - PETAL	1
MS - BYRAM	43	MS - QUITMAN	92
MS - CENTREVILLE	6	MS - SOUTHAVEN	8
MS - CLARKSDALE	16	MS - STARKVILLE	18
MS - COLDWATER	3	MS - SUMRALL	1
MS - COLUMBIA	7	MS - TUPELO	13
MS - CORINTH	10	MS - VICKSBURG	2
MS - DREW	1	MS - WEST POINT	4
MS - FLOWOOD	17	TN - BARTLETT	5
MS - GREENVILLE	253	TN - CORDOVA	3
MS - GREENWOOD	37	TN - GERMANTOWN	4
MS - GRENADA	1	TN - MEMPHIS	38
MS - HAMILTON	1	TN - NASHVILLE	18
		OTHER STATES	10

Currently in the UPDL, methadone is a preferred product with a quantity limit of 62 tablets per 31 days (a dosing limit) but no cumulative quantity limit over time.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS, NARCOTIC - LONG ACTING SmartPA			
	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) IONSYS (fentanyl)NK 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)	**Minimum Age Limit** • **18 years** – Xartemis XR, Zohydro ER **Quantity Limits** Applicable quantity limit per rolling days • **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 **Non-Preferred Criteria** • 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

Based on these finding, MS-DUR makes the following recommendations and requests additional input from the board:

1. The DUR Board requests that the P&T Committee considers changing methadone from preferred to non-preferred due to beneficiary safety concerns..

2. The DUR Board request MSDUR continue to perform analysis and educational interventions.

QUALITY OF CARE ASSURANCE IN USE OF ANTIPSYCHOTICS IN CHILDREN

Version July 19, 2015

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.

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 (*this is a DUR activity*)**.
2. CMS should work with State Medicaid programs to conduct periodic reviews of medical records associated with claims for SGAs prescribed to children (*this would be responsibility of Medical Bureau*).
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. They also recommended use of the Healthcare Effectiveness Data and Information Set (HEDIS) measures where appropriate.

Guidances from Florida and Texas Medicaid programs were reviewed along with the OIG report and the following measures were identified that are associated with the OIG quality of care criteria evaluated. Quality measures were identified where appropriate. Some of these measures have been addressed by MS-DUR previously and those results are summarized. For other measure, a retrospective analysis was conducted using Mississippi Medicaid fee-for-service and managed care medical and pharmacy claims data. Quality of care was analyzed for each measure for the observation period of January 1, 2014 – December 31, 2014. Some measure required the use of data from late 2013 to determine new medication starts.

OIG CRITERIA AND MISSISSIPPI MEDICAID

The OIG evaluation criteria and related guidances and quality measures are summarized below. Information about Mississippi Medicaid performance and/or current utilization efforts are provided for each criteria. NOTE: the quality measures and criteria described below are being evaluated for use in the Mississippi Medicaid with ambulatory patients only and not necessarily considered applicable to treatment in acute inpatient facilities.

Appropriate dosage

Florida and Texas guidances include recommendations for starting doses and maximum doses by age. A HEDIS quality measure also includes recommended levels.

FLORIDA

Dosing Information for APS in Children Under Age 6	
Drug Name	**Dose**
Risperidone	Starting dose: 0.125 mg/day Maximum dose: 1.5 mg/day
Aripiprazole	Starting dose: 1 mg/day Maximum dose: 7.5 mg/day

HEDIS Measure: Use of Higher Than Recommended Dose for Antipsychotics. The percentage of children and adolescents 0-17 of age who were on antipsychotic medication and who received two or more antipsychotic medication prescriptions with higher-than-recommended doses (during the measurement year).

Table XXX-A. Antipsychotic Medication Dose Maximums

Antipsychotic	Average Daily Dose Criteria for <13 years	Average Daily Dose Criteria for 13–17 years
Aripiprazole	>15 mg/day	>30 mg/day
Asenapine maleate	>20 mg/day	>20 mg/day
Chlorpromazine hcl	>500 mg/day	>800 mg/day
Clozapine	>300 mg/day	>600 mg/day
Fluphenazine hcl	>10 mg/day	>10 mg/day
Haloperidol	>6 mg/day	>10.5 mg/day
Iloperidone	>24 mg/day	>24 mg/day
Loxapine	>100 mg/day	>100 mg/day
Lurisadone	>80 mg/day	>80 mg/day
Olanzapine	>12.5 mg/day	>20 mg/day
Paliperidone	>15 mg/day	>15 mg/day
Perphenazine	>6 mg/day	>64 mg/day
Pimozide	>10 mg/day	>10 mg/day
Quetiapine fumarate	>300 mg/day	>600 mg/day
Risperidone	>3 mg/day	>6 mg/day
Thioridazine hcl	>120 mg/day	>210 mg/day
Thiothixene	>20 mg/day	>20 mg/day
Ziprasidone hcl	>160 mg/day	>160 mg/day

Utilization review of dosing can be done prospectively as an electronic clinical edit or using retrospective analysis. A major problem with retrospective analysis is that in most claims systems, prescription adjudication does not require the days supply field to be reasonably divisible into the quantity dispensed. This results in computed daily dosing of partial tablets other than ½ tablet that would be reasonable. MS-DUR has run analysis of the HEDIS Measure, but we are not comfortable with the amount of rounding of doses that is required due to the days supply numbers provided in the claims. This limitation could be addressed in prospective electronic approval where an appropriate days supply number could be required as part of adjudication.

Current DOM clinical criteria:

POS adjudication checks maximum dosing allowed based on information in First Data Bank, which is based on the approved prescribing information. No other dosing levels for children are used at this time.

Duration of use

The OIG used the following criteria in their medical record review: (1) a dose reduction should be planned after several months of treatment, (2) the treatment plan should include a plan for discontinuing the drug, and (3) medication trials should be of adequate duration to access the effects of the drug.

Florida guidance includes recommendation that after 6-9 months of stable therapy, dose reduction and potential titration to discontinuation should begin.

Current DOM clinical criteria or interventions:

No current clinical edits or criteria regarding duration of use.

Indications for use

Several organizations have recommended quality measures that look for an appropriate diagnosis for use of antipsychotics. The OIG report used chart audits to determine diagnoses. Attempts to use claims data have been problematic since providers are often reluctant to record mental health diagnoses in insurance claims.

The OIG report listed the following recommendations:

Table 3: Medically Accepted Pediatric Indications for SGAs

SGA	Medically Accepted Pediatric Indication(s)[1]	Age Range
aripiprazole	Schizophrenia	13–17 years
	Mania or mixed episodes associated with bipolar I disorder[2]	10–17 years
	Irritability associated with autistic disorder	6–17 years
olanzapine	Schizophrenia	13–17 years
	Mania or mixed episodes associated with bipolar I disorder	13–17 years
paliperidone	Schizophrenia	12–17 years
quetiapine fumarate	Schizophrenia	13–17 years
	Mania associated with bipolar I disorder	10–17 years
risperidone	Schizophrenia	13–17 years
	Mania or mixed episodes associated with bipolar I disorder	10–17 years
	Irritability associated with autistic disorder	5–16 years
	Behavioral syndrome-mental retardation	--[3]
	Pervasive developmental disorder	--[3]

[1]Medically accepted indications include both the uses approved by FDA and those uses, including off-label uses, supported by one or more of the compendia.

[2] Bipolar disorder is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to perform daily tasks. There are two primary forms of bipolar disorder: bipolar I disorder and bipolar II disorder. Each of these two types of bipolar disorder have distinct and separate symptoms.

[3]The FDA-approved uses for risperidone have specific age ranges; the compendia-supported indications do not have specific age ranges, but are simply noted as "pediatric use."

Source: OIG analysis of compendia information, 2014.

The National Collaborative for Innovation in Quality Measurement (NCINQ) proposed a measure for use in Medicaid programs. The measure has not been incorporated into the Child Core Measure Set at this time. Unlike the OIG chart that is based on FDA labeling, the NCINQ measure does not take into account the age of the child.

NCINQ Measure: Supportive Diagnosis for Children and Adolescents Using Antipsychotics. The percentage of children 0-20 years of age on any antipsychotic during the measurement year who do not have a primary (first-line) indication for antipsychotic use.

NCINQ - Table 2. Codes to Identify Primary Indication for Antipsychotic Medication Use

Diagnostic Cluster	ICD-9 CM	Code Description
Schizophrenia Spectrum	295.xx	Schizophrenia
	297.xx	Delusional disorders
	298.xx	Other nonorganic psychoses
Bipolar Disorders (excludes cyclothymia)	296.0x	Manic disorder, single episode
	296.1x	Manic disorder, recurrent episode
	296.4x	Bipolar affective disorder, manic
	296.5x	Bipolar affective disorder, depressed
	296.6x	Bipolar affective disorder, mixed
	296.7x	Bipolar affective disorder, unspecified
	296.8x	Manic-depressive psychosis, other and unspecified
	295.xx	Manic disorder, single episode
	297.xx	Manic disorder, recurrent episode
	298.xx	Bipolar affective disorder, manic
Autism & Pervasive Developmental Disorders (PDD)	299.0-299.01	Autistic disorder
	299.1-299.11	Disintegrative Disorder
	299.8-299.81	Asperger's
	299.9-299.91	Unspecified Childhood Psychosis
Tic Disorders	3072	Tics
	30720	Tic Disorder, Unspecified
	30721	Transient Tic Disorder
	30722	Chronic Motor Or Vocal Tic Disorder
	30723	Tourette's Disorder
Depressive Disorders with Psychotic Symptoms	296.24	Major depressive disorder, single episode, severe with psychotic features
	296.34	Major depressive disorder, recurrent, severe with psychotic features

Results for Mississippi Medicaid on the NCINQ measure during 2014 are shown in Table 1. Overall, approximately 68% of the children taking antipsychotics in 2014 did not have a medical claim with a primary indication supporting the use of antipsychotics. This rate did not vary much by age of the child or by Medicaid pharmacy program. In previous discussions, the Board has suspected that this may occur due to a reluctance of providers to "label" a child with a diagnosis that will follow them throughout life. Although the OIG identified this as a potential measure of quality of care, these results illustrate the need to use medical chart reviews instead of claims data to assess whether an appropriate diagnosis is present.

TABLE 1: Mississippi Medicaid 2014 NCINQ Measure - Percent of Children Taking Antipsychotics Who Do Not Have a Primary Indication for Antipsychotic Use *(NOTE: Lower number is better)*						
			Medicaid Pharmacy Program			
			FFS	Magnolia	UHC	TOTAL
All Children		# w/o Diagnosis	4693	748	549	5990
		# on AP	6796	1151	888	8835
		Percentage	69.1%	65.0%	61.8%	67.8%
Age Group	5 or under	# w/o Diagnosis	131	14	2	147
		# on AP	185	22	13	220
		Percentage	70.8%	63.6%	15.4%	66.8%
	6 to 11	# w/o Diagnosis	1821	226	162	2209
		# on AP	2375	325	246	2946
		Percentage	76.7%	69.5%	65.9%	75.0%
	12 to 17	# w/o Diagnosis	2382	373	253	3008
		# on AP	3528	529	372	4429
		Percentage	67.5%	70.5%	68.0%	67.9%
	18 to 20	# w/o Diagnosis	359	135	132	626
		# on AP	708	275	257	1240
		Percentage	50.7%	49.1%	51.4%	50.5%

Another quality measure of appropriate indication for use of antipsychotics has been whether a mental health assessment was performed prior to initiating therapy and if behavioral therapy is performed while on drug therapy. HEDIS has a quality measure that addresses this issues.

HEDIS Measure: Use of First-Line Psychosocial Care for Children and Adolescents on APs. The percentage of children and adolescents 0-17 of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment (psychosocial care received within 90 days before or 30 days after first starting antipsychotic therapy).

Current DOM clinical criteria or interventions:

No current clinical edits or criteria regarding appropriate diagnosis except when an age waiver is required. When requesting an age waiver, a diagnosis and a statement of medical justification are required.

Monitoring

Evaluating this criteria would require chart audits, similar to what was performed in the OIG study. This cannot be accomplished through utilization review.

Although it cannot address the nature of the monitoring, HEDIS has a quality measure that addresses whether follow-up occurred after initiating therapy.

HEDIS Measure: Follow-up Visit for Children and Adolescents on Antipsychotics. The percentage of children and adolescents 0-17 of age who had a new prescription for an antipsychotic medication and had one or more follow-up visits with a prescriber (within 30 days of starting antipsychotic therapy).

Results for Mississippi Medicaid on this HEDIS measure during 2014 are shown in Table 2. Overall, only 14% of the children starting a new antipsychotic prescription in 2014 had a follow-up office visit with a prescriber within 30 days. This rate varied somewhat among Medicaid pharmacy programs and by age of the child. Younger children was the least likely to have a documented follow-up visit.

TABLE 2: Mississippi Medicaid 2014
HEDIS Measure - Percent of Children Having New Antipsychotic Prescriptions Who Had One or More Follow-up Vistis With a Prescriber *(NOTE: Higher number is better)*

			Medicaid Pharmacy Program			
			FFS	Magnolia	UHC	TOTAL
All Children		# Follow-up	688	98	54	840
		# New Rx	4,595	793	557	5,945
		Percentage	15.0%	12.4%	9.7%	14.1%
Age Group	5 or under	# Follow-up	7	2	0	9
		# New Rx	123	24	15	162
		Percentage	5.7%	8.3%	0.0%	5.6%
	6 to 11	# Follow-up	177	23	14	214
		# New Rx	1,816	315	229	2,360
		Percentage	9.7%	7.3%	6.1%	9.1%
	12 to 17	# Follow-up	504	73	40	617
		# New Rx	2,656	454	313	3,423
		Percentage	19.0%	16.1%	12.8%	18.0%

Current DOM clinical criteria or interventions:

No current clinical edits or criteria regarding the type of monitoring described in the OIG criteria. Monitoring for changes in behavior and for most side effects cannot be done through utilization review but would require medical record review by the Medical Bureau and not through pharmacy.

Polypharmacy

All guidelines recommend that monotherapy should be tried before treatment with multiple drugs. They also say that there needs to be a clearly documented rationale regarding the need for each drug when a child is treated with multiple drugs.

Texas has an electronic prior authorization edit that will reject a claim for a second antipsychotic medication being taking concurrently, forcing a manual PA review. HEDIS has a quality measure addressing polypharmacy with antipsychotics.

HEDIS Measure: Use of Multiple Concurrent Antipsychotics. The percentage of children and adolescents 0-17 of age taking antipsychotic medications (90+ continuous days) who were on two or more concurrent antipsychotic medications (90+ days of continuous concurrent therapy).

Results for Mississippi Medicaid on this HEDIS measure during 2014 are shown in Table 3. Overall, 3% of the children taking antipsychotics took two or more antipsychotics concurrently for more than 90 continuous days. This rate was higher in the FFS program. This is probably due to the fact that the HEDIS measure does not exclude children receiving care in residential programs and these children cannot be easily identified and excluded from the data for the FFS program. Younger children were less likely than older children to be on concurrent medications.

TABLE 3: Mississippi Medicaid 2014
HEDIS Measure - Percent of Children Taking Antipsychotics Who Were on Two or More Concurrent Antypsychotics
(NOTE: Lower number is better)

			Medicaid Pharmacy Program			
			FFS	MAG	UHC	TOTAL
All Children		# on concurrent APs	101	5	8	114
		# taking APs	2901	482	381	3764
		Percentage	3.5%	1.0%	2.1%	3.0%
Age Group	5 or under	# on concurrent APs	1	0	0	1
		# taking APs	70	15	10	95
		Percentage	1.4%	0.0%	0.0%	1.1%
	6 to 11	# on concurrent APs	28	2	3	33
		# taking APs	1230	205	159	1594
		Percentage	2.3%	1.0%	1.9%	2.1%
	12 to 17	# on concurrent APs	72	3	5	80
		# taking APs	1601	262	212	2075
		Percentage	4.5%	1.1%	2.4%	3.9%

NOTE: HEDIS measure does not exclude children receiving care in residential treatment units.

Current DOM clinical criteria or interventions:

At the February 2015 DUR Board Meeting the following recommendations were approved:

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.

DOM is currently exploring changes in the SmartPA rule for atypical antipsychotics and the manual PA criteria that will accomplish this.

Side effects

Two HEDIS measures address the monitoring of metabolic side effects.

HEDIS Measure: Metabolic Screening for Children and Adolescents Newly On Antipsychotics. The percentage of children and adolescents 0-17 years of age who had a new prescription for an antipsychotic medication and had baseline metabolic screening (screening within 90 days prior to 15 days after initiating therapy).

Results for Mississippi Medicaid on this HEDIS measure during 2014 are shown in Table 4. Overall, 14% of the children starting antipsychotics received baseline metabolic screening. This rate varied somewhat across Medicaid pharmacy programs and increased with the age of the beneficiary.

TABLE 4: Mississippi Medicaid 2014
HEDIS Measure - Percent of Children Starting Antipsychotics Who Had Baseline Metabolic Screening
(NOTE: Higher number is better)

			Medicaid Pharmacy Program			
			FFS	Magnolia	UHC	TOTAL
All Children		# With Screening	688	98	54	840
		# Starting APs	4,595	793	557	5,945
		Percentage	15.0%	12.4%	9.7%	14.1%
Age Group	5 or under	# With Screening	7	2	0	9
		# Starting APs	123	24	15	162
		Percentage	5.7%	8.3%	0.0%	5.6%
	6 to 11	# With Screening	177	23	14	214
		# Starting APs	1,816	315	229	2,360
		Percentage	9.7%	7.3%	6.1%	9.1%
	12 to 17	# With Screening	504	73	40	617
		# Starting APs	2,656	454	313	3,423
		Percentage	19.0%	16.1%	12.8%	18.0%

HEDIS Measure: Metabolic Screening for Children and Adolescents On Antipsychotics. The percentage of children and adolescents 0-17 of age who had two or more antipsychotic prescriptions and had metabolic screening (during the observation period).

The NCINQ also proposed a similar measure for use in the Medicaid Child Core Set.

NCINQ Measure: Metabolic Screening for Children and Adolescents on Antipsychotics. The percentage of children 0 to 20 years of age on any antipsychotic who had metabolic screening documented during the measurement year.

Results for Mississippi Medicaid on the NCINQ measure for the period July 2013 through June 2014 were reported at the November 2014 DUR Board Meeting. Overall only 15% of children taking antipsychotics had metabolic screening during the year. The percentages varied slightly among the Medicaid pharmacy programs.

TABLE 5: Mississippi Medicaid July 2013 - June 2014
NCINQ Measure - Percent of Children Taking Antipsychotics Who Had Metabolic Screening
(NOTE: Higher number is better)

		FFS		UHC		Magnolia		TOTAL	
Measure	**Age Group**	# on APs	% Having Test	# on APs	% Having Test	# on APs	% Having Test	# on APs	% Having Test
Blood glucose test	<=5	151	22.5%	20	20.0%	40	22.5%	211	22.2%
	6-11	2,162	22.4%	303	22.4%	447	19.9%	2,912	22.0%
	12-17	3,267	34.0%	475	26.9%	763	30.0%	4,505	32.4%
	18-20	583	41.0%	303	36.6%	398	41.2%	1,284	39.9%
Cholesterol test	<=5	151	8.6%	20	5.0%	40	7.5%	211	7.9%
	6-11	2,162	9.0%	303	9.6%	447	8.9%	2,912	9.1%
	12-17	3,267	17.9%	475	14.1%	763	16.0%	4,505	17.1%
	18-20	583	16.8%	303	13.5%	398	16.6%	1,284	15.8%
Both tests	<=5	151	7.9%	20	5.0%	40	7.5%	211	7.4%
	6-11	2,162	8.2%	303	8.6%	447	7.8%	2,912	8.2%
	12-17	3,267	16.7%	475	12.2%	763	14.8%	4,505	15.7%
	18-20	583	15.4%	303	13.5%	398	15.3%	1,284	14.9%

Current DOM clinical criteria or interventions:

At the February 2015 DUR Board Meeting the following recommendations were approved:

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.

MS-DUR is in the process of finalizing an article for publication in state medical journals on the need for metabolic monitoring. Intervention mailings were started April 2015 and are currently in the second cycle of contacting prescribers. A follow-up evaluation of changes in the HEDIS measure for any screening will be conducted after 6 months of intervention.

Patient age

It is difficult to evaluate appropriateness of treatment for young children since product labeling often does not address the need at early ages. Labeled indications and ages can be used (see OIG chart in section addressing Indication for Use). Other approaches have been to use quality measures regarding percentage of children being treated with antipsychotics below certain ages.

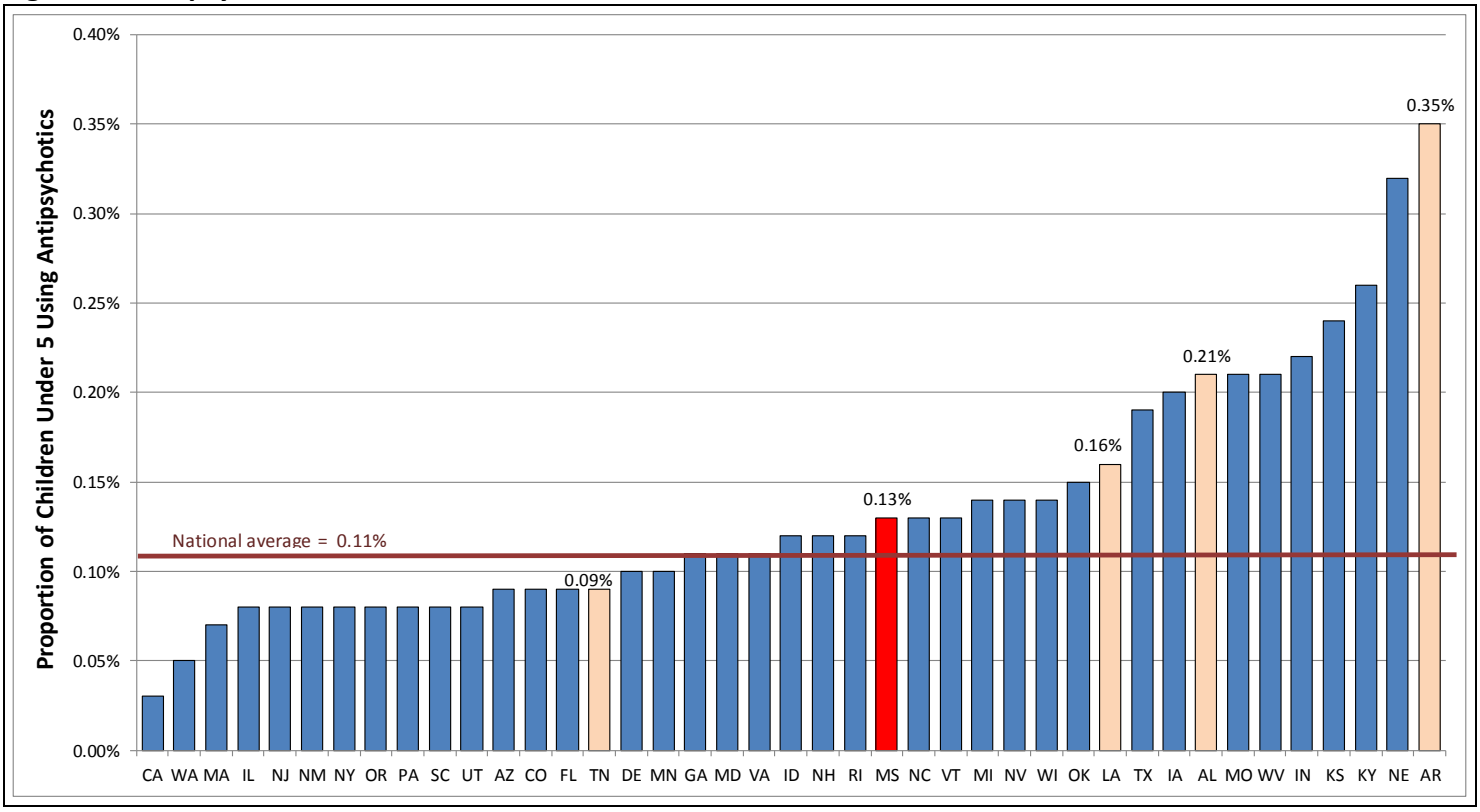
PQA Measure: Antipsychotic Use in Children Under 5 Years Old. The percentage of children under age 5 using antipsychotic medications during the measurement period.

Results for Mississippi Medicaid on the PQA measure for the period January – December 2012 were reported at the July 2013 DUR Board Meeting. Overall 0.11% of children under 5 years of age were taking antipsychotics (Table 6). As shown in Figure 1, an MS-DUR analysis of national Medicaid data for 2007 found that Mississippi Medicaid was just above the national average on this measure.

TABLE 6: Use of Antipsychotics Among Children Under 5 Years Old 2012 Mississippi Medicaid Data

	ALL BENES		FOSTER CHILDREN		NON-FOSTER	
	Numerator	Rate	Numerator	Rate	Numerator	Rate
167,482	184	0.11%	9	0.68%	175	0.11%

Figure 1: Antipsychotic Use in Children Under 5 Years Old – 2007 CMS Medicaid MAX Data



Current DOM clinical criteria or interventions:

Age limits in SmartPA that require manual PA if not met.
Minimum Age Limits

- 3 years - haloperidol
- 5 years – risperidone
- 6 years – aripiprazole
- 10 years – asenapine, olanzapine/fluoxetine, quetiapine
- 13 years – olanzapine
- 18 years – clozapine, iloperidone, lurasidone, paliperidone, ziprasidone

When an age waiver is requested using manual PA, a diagnosis and a statement of medical justification are required.