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

MISSISSIPPI DIVISION OF
MEDICAID

March 19, 2026 at 1:00pm

Walter Sillers Building, Cobb Conference Room

Jackson, MS

Prepared by:

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

Drug Utilization Review Board

Amy Catherine Baggett, PharmD
Love's Pharmacy of Diamondhead
45000 E Aloha Dr., Suite B
Diamondhead, MS 39525
Term Expires: June 30, 2027

Terrence Brown, PharmD
BioScrip Infusion Services
187 Country Place Pkwy, Suite C
Pearl, MS 39208
Term Expires: June 30, 2026

Greg Browning, MD
Premier Medical Group
332 MS-12
Kosciusko, MS 39090
Term Expires: June 30, 2028

Rachel Burt, PharmD
Walmart Pharmacy
2530 Jackson Avenue West
Oxford, MS 38655
Term Expires: June 30, 2026

Steven Clark, MD
Cleveland Medical Clinic
810 East Sunflower Road
Cleveland, MS 38732
Term Expires: June 30, 2028

Chrysanthia Davis, PharmD
Omnicare Pharmacy
100 Business Park Dr, Suite D
Ridgeland, MS 39157
Term Expires: June 30, 2028

Dena Jackson, MD
King's Daughters Specialty Clinic
940 Brookway Blvd
Brookhaven, MS 39601
Term Expires: June 30, 2026

Jessica Lavender, MD
UMMC
2500 N. State Street
Jackson, MS 39216
Term Expires: June 30, 2028

Holly R. Moore, PharmD
Anderson Regional Medical Center
2124 14th Street
Meridian, MS 39301
Term Expires: June 30, 2026

Joshua Pierce, PharmD (Chair)
McGuffee Drugs
102 Main Street
Magee, MS 39111
Term Expires: June 30, 2027

Gaylen Sanders, MD
The Pediatric Clinic
415 South 28th Avenue
Hattiesburg, MS 39401
Term Expires: June 30, 2027

Joshua Trull, DO
UMMC Dept of Psychiatry
2500 N. State Street
Jackson, MS 39216
Term Expires: June 30, 2027

2026 DUR Board Meeting Dates

March 19, 2026
June 11, 2026
September 10, 2026
December 10, 2026

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.

Unless otherwise indicated, all MS-DUR analyses are conducted for the entire Mississippi Medicaid program including beneficiaries receiving services through the Medicaid fee-for-service (FFS) and the Mississippi Medicaid Coordinated Care Organizations (CCOs). When dollar figures are reported, the reported dollar figures represent reimbursement amounts paid to providers and are not representative of final Medicaid costs after rebates. Any reported enrollment data 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 Universal Preferred Drug List (PDL).

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

MISSISSIPPI DIVISION OF MEDICAID
OFFICE OF THE GOVERNOR
DRUG UTILIZATION REVIEW BOARD
AGENDA
March 19, 2026

Welcome

Old Business

Resource Utilization Review

Follow-up and Discussion from the Board page 20

New Business

Pharmacy Program Update

Next Meeting Information
June 11, 2026

DUR Board Meeting Minutes

MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE DECEMBER 11, 2025 MEETING

DUR Board Roster: State Fiscal Year 2025 (July 1, 2025 – June 30, 2026)	**Mar 2025**	**Jun 2025**	**Sep 2025**	**Dec 2025**
Amy Catherine Baggett, PharmD	✓		✓	
Terrence Brown, PharmD	✓	✓	✓	✓
Greg Browning, MD	NA	NA	✓	✓
Rachel Burt, PharmD	NA	NA	✓	✓
Steven Clark, MD	NA	NA	✓	✓
Chrysanthia Davis, PharmD	✓	✓	✓	✓
Dena Jackson, MD	✓	✓		✓
Jessica Lavender, MD	✓	✓	✓	
Holly Moore, PharmD	✓		✓	
Joshua Pierce, PharmD	✓	✓	✓	✓
Gaylen Sanders, MD	✓	✓	✓	✓
Joshua Trull, DO	✓		✓	✓
TOTAL PRESENT**	**11**	**7**	**11**	**9**

** *Total Present may not be reflected by individual members marked as present above due to members who either resigned or whose terms expired being removed from the list.*

Also Present:

Division of Medicaid (DOM) Staff:
Dennis Smith, RPH, DUR Coordinator; Amy Ly-Ha, PharmD, Pharmacist II;

University of Mississippi School of Pharmacy - MS-DUR Staff:
Eric Pittman, PharmD, PhD, MS-DUR Project Director; Kaustuv Bhattacharya, PhD, MS-DUR Research Assistant Professor; John Bentley, PhD, CPMM Director;

Coordinated Care Organization (CCO) Staff:
Jenni Grantham, PharmD, Director of Pharmacy, Magnolia Health; John Mitchell, TrueCare;

Gainwell Staff:
Lew Ann Snow, RN, Advisor Business Analyst; Tricia Banks, PharmD, Director of Pharmacy;

Teligen Staff:
Buddy Ogletree, PharmD, Pharmacist;

Visitors: Paula Whatley, Novo Nordisk; David Large, Chiesi GRD; Thomas Dobbs, UMMC;

Call to Order/Welcome:

The meeting began at 1:06 pm.

OLD BUSINESS:
Dr. Davis moved to approve the minutes from the September 2025 DUR Board Meeting, seconded by Dr. Brown, and unanimously approved by the DUR Board.

Resource Utilization Review
Dr. Pittman presented the resource utilization report for September 2025. Data presented was across all pharmacy programs.

NEW BUSINESS:

Update on MS-DUR Educational Interventions
Dr. Pittman provided an overview of all DUR mailings and educational notices that occurred between September 2025 and November 2025. Dr. Pittman also provided the Board with an update on educational efforts DUR/Medicaid have engaged in regarding the need for increased RSV protection for infants. An educational letter was developed and distributed to multiple provider groups across Mississippi.

Human Immunodeficiency Virus (HIV) Pre-Exposure Prophylaxis (PrEP) Utilization
Prevention of new HIV infections using PrEP is essential in the fight to eliminate HIV in the U.S. When taken as directed, PrEP has been found to be highly effective at preventing HIV; however, multiple barriers have impeded uptake. While PrEP therapy is part of Medicaid's Universal Preferred Drug List (UPDL), uptake has been limited across the state. Guest presenter Dr. Thomas Dobbs gave the Board some insights into the state of HIV prevention and treatment in Mississippi. At the conclusion of a robust discussion, the following recommendation was presented:

1. The DOM should conduct provider education on PrEP therapy to include:
    - Incidence rates for HIV infections in Mississippi.
    - Categories of individuals identified as being high risk for acquiring HIV infection.
    - Preferred status of PrEP products on UPDL.
    - Inclusion of PrEP products as covered medications under the Family Planning Waiver for both males and females.
    - Need for more providers around the state to identify high-risk members and prescribe PrEP.
    - Stigma reduction recommendations.

Dr. Brown made a motion to approve the recommendation, seconded by Dr. Davis, and unanimously approved by the Board.

HIV Antiretroviral Therapy (ART) Adherence

Adherence to antiretroviral therapy is crucial in attaining viral suppression and optimal outcomes among individuals treated for HIV. ART adherence of ≥ 90% is the recognized threshold for achieving viral suppression. Among Medicaid members included in the analysis, 34.87% of members receiving ART in 2024 achieved a proportion of days-covered (PDC) ≥ 90%, down from 42.11% in 2019, while only 7.58% of members on injectable ART therapy with Cabenuva® achieved PDC ≥ 90%. Opportunities exist to improve adherence to antiretroviral therapy among Medicaid members. Concluding discussion, the following recommendations were presented:

1. DOM should collaborate with Mississippi State Department of Health, infectious disease practice groups, and state medical/pharmacy/nursing associations on strategies to improve ART adherence among Medicaid members.

2. DOM should conduct targeted outreach to providers with members who have low ART adherence.

Dr. Burt made a motion to approve the recommendations, seconded by Dr. Brown, and unanimously approved by the Board.

Trends, Treatment Patterns, and Healthcare Utilization Associated with Migraine-related Medications

Migraine treatment has transformed since the introduction of calcitonin gene-related peptide (CGRP) therapy. Since 2018, these breakthrough medications have accounted for over half of Mississippi Medicaid's expenditures on migraine-related therapies. While the use of migraine preventive therapies has been shown to reduce migraine-related ED visits and hospitalizations, many members require the concurrent use of acute medications along with their preventive therapy, including those members taking preventive CGRP therapies. Considering the significant financial impact of CGRP inhibitors, DOM must ensure the appropriate clinical use of these therapies in the treatment of migraine. DOM asked the DUR Board to review its current criteria for CGRP inhibitors and provide input. Following discussion, the Board affirmed Medicaid's current criteria with the exception of recommending DOM consider removing the criteria for consultation with a specialist.

Dr. Jackson made a motion to approve the recommendation, seconded by Dr. Clark, and unanimously approved by the Board.

Weight Changes Associated with the Initiation of Glucagon-like Peptide-1 Receptor Agonist (GLP-1 RA) Anti-Obesity Medications (AOMs)

Obesity is a chronic, relapsing condition that affects a substantial portion of the population and is linked to more than 60 comorbidities. Even modest weight reduction can lead to meaningful improvements in many of these conditions. Of note, 40% of members in the study cohort had a body mass index (BMI) of 45 or greater at baseline, and over 80% initiated treatment with a BMI exceeding 35. Among Medicaid members who initiated GLP-1 RA AOMs between July 2023

and June 2024 and had follow-up prior authorization data available, 57% of those in the 6-month cohort and 64.4% of those in the 12-month cohort achieved at least 5% weight loss. Patterns of medication use—including adherence, persistence, and lack of medication switching—were strongly and consistently associated with achieving weight loss.

No formal recommendations were made in reference to this report.

FDA Drug Safety Updates:
The FDA issued no new drug safety updates between September and November 2025.

Pharmacy Program Update:
The following items were included in the pharmacy program update:

- The Board was encouraged the subscribe to Medicaid's Late Breaking News Listserv.
- Medicaid reminded pharmacies to submit the correct national drug code (NDC) for items dispensed.
- New PDL changes will go into effect January 1, 2026. A copy of the provider notice detailing all changes was distributed to the Board.

Next Meeting Information:
Potential 2026 DUR meeting dates: March 5 or 19, 2026; June 11, 2026; September 10, 2026; December 10, 2026.

Dr. Pierce adjourned the meeting at 2:38 pm.

Submitted,

Eric Pittman, PharmD, PhD
Evidence-Based DUR Initiative, MS-DUR

DUR Board Meeting Resources

Members

The DUR Board is composed of twelve participating Medicaid providers who are in good standing with their representative organizations.

- DUR Board Member List

Meetings

Meetings will be held on the following dates at 1:00 p.m. in the Cobb Conference Room at 550 High St, Jackson, MS (**see map**).

- March 20, 2025
- June 12, 2025
- September 18, 2025
- December 11, 2025

The September 18 meeting may be viewed virtually by clicking on the following link:
Click Here for MS Medicaid DUR Live Broadcast on December 11, 2025, at 1:00 p.m.

Please note: This link will only be live during the meeting and will not be archived for future viewing.

Resource Utilizaton Review

TABLE 04A: ENROLLMENT STATISTICS FOR LAST 6 MONTHS
July 1, 2025 through December 31, 2025

			Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Total enrollment			719,239	717,803	714,735	711,574	709,243	705,826
Dual-eligibles			163,451	163,434	163,710	163,628	163,749	161,943
Pharmacy benefits			556,720	555,519	553,274	550,920	548,243	545,799
	LTC		15,819	15,831	15,826	15,829	15,672	15,402
	PLAN %	**FFS**	21.7%	21.4%	20.8%	19.3%	17.6%	17.5%
		MSCAN-UHC	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
		MSCAN-Magnolia	37.6%	38.0%	38.3%	39.0%	39.7%	39.8%
		MSCAN-Molina	23.9%	24.1%	24.4%	25.0%	25.6%	25.7%
		MSCAN-TrueCare	16.7%	16.4%	16.4%	16.6%	17.0%	16.9%

TABLE 04B: PHARMACY UTILIZATION STATISTICS FOR LAST 6 MONTHS
July 1, 2025 through December 31, 2025

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
# Rx Fills	**FFS**	92,558	97,702	97,196	95,214	83,524	90,977
	MSCAN-UHC	284	244	239	274	253	281
	MSCAN-Mag	160,783	180,535	177,579	180,165	171,153	183,406
	MSCAN-Mol	82,963	95,230	93,797	95,707	91,438	99,077
	MSCAN-Tru	65,376	72,733	70,785	71,721	68,124	73,659
# Rx Fills / Bene	**FFS**	0.8	0.8	0.8	0.9	0.9	1.0
	MSCAN-UHC	0.5	0.4	0.4	0.5	0.5	0.5
	MSCAN-Mag	0.8	0.9	0.8	0.8	0.8	0.8
	MSCAN-Mol	0.6	0.7	0.7	0.7	0.7	0.7
	MSCAN-Tru	0.7	0.8	0.8	0.8	0.7	0.8
$ Paid Rx	**FFS**	$14,657,391	$14,352,307	$14,310,513	$14,949,157	$12,511,039	$14,012,179
	MSCAN-UHC	$148,269	$95,296	$87,949	$99,903	$93,407	$100,351
	MSCAN-Mag	$26,521,647	$26,005,853	$26,891,944	$27,855,205	$24,608,103	$28,288,267
	MSCAN-Mol	$13,245,199	$12,541,374	$13,274,666	$13,669,421	$12,156,553	$13,765,067
	MSCAN-Tru	$10,609,342	$9,829,963	$10,571,643	$10,602,155	$9,719,754	$10,910,646
$ /Rx Fill	**FFS**	$158.36	$146.90	$147.23	$157.01	$149.79	$154.02
	MSCAN-UHC	$522.07	$390.56	$367.99	$364.61	$369.20	$357.12
	MSCAN-Mag	$164.95	$144.05	$151.44	$154.61	$143.78	$154.24
	MSCAN-Mol	$159.65	$131.70	$141.53	$142.83	$132.95	$138.93
	MSCAN-Tru	$162.28	$135.15	$149.35	$147.82	$142.68	$148.12
$ /Bene	**FFS**	$121.33	$120.73	$124.35	$140.60	$129.66	$146.70
	MSCAN-UHC	$266.33	$171.54	$158.96	$181.34	$170.38	$183.86
	MSCAN-Mag	$126.70	$123.19	$126.91	$129.64	$113.06	$130.22
	MSCAN-Mol	$99.55	$93.68	$98.33	$99.25	$86.62	$98.13
	MSCAN-Tru	$114.11	$107.90	$116.51	$115.93	$104.29	$118.29

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

TABLE C: TOP 10 DRUG CATEGORIES BY NUMBER OF CLAIMS IN DEC 2025 (FFS AND CCOs)

subcategory_top_drug	Month Year	Rank Volume	# RXs	$ Paid	# Unique Benes
CNS stimulants (e.g.,methylphenidate)	Dec 2025	1	23,572	$3,212,461	20,037
	Nov 2025	1	21,812	$2,977,605	19,235
	Oct 2025	1	24,976	$3,345,248	21,367
aminopenicillins (e.g.,amoxicillin)	Dec 2025	2	14,733	$217,256	14,447
	Nov 2025	2	14,058	$204,574	13,867
	Oct 2025	5	12,889	$186,375	12,681
atypical antipsychotics (e.g.,risperidone)	Dec 2025	3	14,427	$5,631,769	11,612
	Nov 2025	3	13,054	$4,786,945	11,068
	Oct 2025	2	14,505	$5,601,860	11,917
adrenergic bronchodilators (e.g.,albuterol)	Dec 2025	4	13,590	$530,995	11,842
	Nov 2025	4	12,946	$505,992	11,343
	Oct 2025	4	12,987	$552,979	11,154
SSRI antidepressants (e.g.,sertraline)	Dec 2025	5	12,921	$165,832	11,595
	Nov 2025	6	11,924	$151,982	11,010
	Oct 2025	3	13,203	$169,265	11,964
glucocorticoids (e.g.,prednisolone)	Dec 2025	6	12,202	$525,638	11,720
	Nov 2025	5	12,021	$452,948	11,598
	Oct 2025	9	10,608	$420,573	10,248
nonsteroidal anti-inflammatory agents (e.g.,ibuprofen)	Dec 2025	7	12,118	$161,321	11,592
	Nov 2025	7	11,172	$150,068	10,763
	Oct 2025	6	12,307	$166,770	11,743
antiadrenergic agents, centrally acting (e.g.,clonidine)	Dec 2025	8	12,022	$197,502	10,566
	Nov 2025	8	10,975	$175,474	9,975
	Oct 2025	7	12,159	$190,145	10,768
antihistamines (e.g.,cetirizine)	Dec 2025	9	10,768	$179,467	10,250
	Nov 2025	9	10,623	$180,594	10,303
	Oct 2025	8	11,227	$192,097	10,749
macrolides (e.g.,azithromycin)	Dec 2025	10	10,563	$189,072	10,376
	Nov 2025	10	10,237	$182,671	10,065
	Oct 2025	13	8,409	$154,683	8,232

TABLE D: TOP 10 DRUG CATEGORIES BY DOLLARS PAID IN DEC 2025 (FFS AND CCOs)

subcategory_top_drug	Month Year	Rank Paid Amt	# RXs	$ Paid	# Unique Benes
interleukin inhibitors (e.g.,dupilumab)	Dec 2025	1	1,074	$6,722,522	973
	Nov 2025	1	955	$5,595,063	900
	Oct 2025	1	1,071	$6,578,857	960
atypical antipsychotics (e.g.,paliperidone)	Dec 2025	2	14,427	$5,631,769	11,612
	Nov 2025	2	13,054	$4,786,945	11,068
	Oct 2025	2	14,505	$5,601,860	11,917
GLP-1 receptor agonists for obesity (e.g.,semaglutide)	Dec 2025	3	3,564	$4,628,349	3,268
	Nov 2025	3	3,197	$4,155,030	3,072
	Oct 2025	3	3,466	$4,510,626	3,183
TNF alpha inhibitors (e.g.,adalimumab)	Dec 2025	4	471	$3,896,261	401
	Nov 2025	4	379	$3,162,405	361
	Oct 2025	4	434	$3,689,645	389
CNS stimulants (e.g.,methylphenidate)	Dec 2025	5	23,572	$3,212,461	20,037
	Nov 2025	5	21,812	$2,977,605	19,235
	Oct 2025	5	24,976	$3,345,248	21,367
antiviral combinations (e.g.,bictegravir/emtricitabine/tenofovir)	Dec 2025	6	656	$2,592,807	599
	Nov 2025	6	590	$2,351,646	562
	Oct 2025	7	627	$2,438,120	591
GLP-1 receptor agonists for non-obesity indications (e.g.,dulaglutide)	Dec 2025	7	2,689	$2,530,014	2,470
	Nov 2025	7	2,444	$2,303,839	2,345
	Oct 2025	6	2,682	$2,537,697	2,504
CFTR combinations (e.g.,elexacaftor/ivacaftor/tezacaftor)	Dec 2025	8	91	$2,441,568	79
	Nov 2025	8	85	$2,251,412	79
	Oct 2025	8	88	$2,381,612	80
factor for bleeding disorders (e.g.,emicizumab)	Dec 2025	9	156	$2,293,244	124
	Nov 2025	10	135	$1,606,454	115
	Oct 2025	9	148	$2,131,481	119
SGLT-2 inhibitors (e.g.,empagliflozin)	Dec 2025	10	2,261	$1,849,819	2,116
	Nov 2025	9	2,198	$1,760,950	2,098
	Oct 2025	10	2,354	$1,933,560	2,219

TABLE E: TOP 25 DRUG MOLECULES
BY NUMBER OF CLAIMS IN DEC 2025 (FFS and CCOs)

Drug Molecule Therapeutic Category	Nov 2025 # Claims	Dec 2025 # Claims	Dec 2025 $ Paid	Dec 2025 # Unique Benes
amoxicillin / aminopenicillins	14,040	14,706	$213,875	14,422
albuterol / adrenergic bronchodilators	12,437	13,068	$388,466	11,461
azithromycin / macrolides	10,015	10,358	$159,567	10,192
methylphenidate / CNS stimulants	7,865	8,374	$1,578,552	7,312
ondansetron / 5HT3 receptor antagonists	7,908	8,267	$125,265	7,941
oseltamivir / neuraminidase inhibitors	2,259	7,920	$200,115	7,889
amphetamine-dextroamphetamine / CNS stimulants	6,763	7,503	$215,022	6,356
clonidine / antiadrenergic agents, centrally acting	6,742	7,387	$111,093	6,788
cetirizine / antihistamines	7,206	7,069	$118,344	6,904
ibuprofen / nonsteroidal anti-inflammatory agents	6,000	6,732	$85,597	6,572
gabapentin / gamma-aminobutyric acid analogs	5,598	6,134	$95,294	5,642
fluticasone nasal / nasal steroids	6,539	6,123	$107,384	6,033
prednisolone / glucocorticoids	6,078	6,076	$123,683	5,875
amoxicillin-clavulanate / penicillins/beta-lactamase inhibitors	5,676	5,959	$120,220	5,882
cefdinir / third generation cephalosporins	5,656	5,951	$123,298	5,883
montelukast / leukotriene modifiers	5,584	5,604	$80,161	5,418
sertraline / SSRI antidepressants	4,845	5,255	$64,472	4,709
ergocalciferol / vitamins	4,419	4,775	$43,798	3,802
acetaminophen-hydrocodone / narcotic analgesic combinations	4,443	4,733	$85,039	4,426
guanfacine / antiadrenergic agents, centrally acting	4,232	4,633	$85,894	4,292
amlodipine / calcium channel blocking agents	4,142	4,534	$72,765	4,196
pantoprazole / proton pump inhibitors	3,962	4,311	$54,218	4,008
hydroxyzine / miscellaneous anxiolytics, sedatives and hypnotics	4,004	4,229	$71,164	3,989
omeprazole / proton pump inhibitors	3,930	4,130	$51,562	3,935
atorvastatin / HMG-CoA reductase inhibitors (statins)	3,708	4,034	$48,289	3,602

TABLE F: TOP 25 DRUG MOLECULES
BY DOLLARS PAID IN DEC 2025 (FFS and CCOs)

Drug Molecule Therapeutic Category	Nov 2025 $ Paid	Dec 2025 $ Paid	Dec 2025 # Claims	Dec 2025 # Unique Benes
semaglutide / GLP-1 receptor agonists for obesity	$4,080,058	$4,531,638	3,474	3,187
dupilumab / interleukin inhibitors	$2,797,620	$3,055,989	760	688
adalimumab / TNF alpha inhibitors	$2,422,257	$2,914,653	304	254
paliperidone / atypical antipsychotics	$1,872,354	$2,407,399	741	632
elexacaftor/ivacaftor/tezacaftor / CFTR combinations	$2,052,503	$2,185,829	82	70
dulaglutide / GLP-1 receptor agonists for non-obesity indications	$1,781,443	$1,938,405	2,040	1,881
aripiprazole / atypical antipsychotics	$1,409,900	$1,593,379	3,838	3,450
methylphenidate / CNS stimulants	$1,516,133	$1,578,552	8,374	7,312
bictegravir/emtricitabine/tenofovir / antiviral combinations	$1,387,385	$1,529,921	341	315
emicizumab / factor for bleeding disorders	$760,133	$1,378,096	44	30
ixekizumab / interleukin inhibitors	$892,368	$988,110	116	107
empagliflozin / SGLT-2 inhibitors	$914,244	$954,796	1,117	1,046
dapagliflozin / SGLT-2 inhibitors	$842,609	$890,927	1,137	1,067
cariprazine / atypical antipsychotics	$761,664	$784,999	545	516
immune globulin intravenous / immune globulins	$554,417	$656,846	31	27
apixaban / factor Xa inhibitors	$600,356	$650,128	1,264	1,112
etanercept / TNF alpha inhibitors	$547,724	$649,308	99	92
cannabidiol / miscellaneous anticonvulsants	$471,315	$562,844	168	146
somatropin / growth hormones	$439,046	$536,289	123	108
antihemophilic factor / factor for bleeding disorders	$428,555	$528,943	14	9
upadacitinib / antirheumatics	$430,553	$523,740	82	76
risperidone / atypical antipsychotics	$404,392	$492,229	4,011	3,494
ustekinumab / interleukin inhibitors	$416,465	$473,680	33	31
budesonide-formoterol / bronchodilator combinations	$446,970	$466,433	1,992	1,928
bimekizumab / interleukin inhibitors	$287,457	$454,755	21	20

TABLE G: TOP 25 DRUG MOLECULES
BY CHANGE IN NUMBER OF CLAIMS FROM OCT 2025 TO DEC 2025 (FFS and CCOs)

Drug Molecule	Oct 2025 # Claims	Nov 2025 # Claims	Dec 2025 # Claims	Dec 2025 $ Paid	Dec 2025 # Unique Benes
oseltamivir / neuraminidase inhibitors	731	2,259	7,920	$200,115	7,889
azithromycin / macrolides	8,197	10,015	10,358	$159,567	10,192
amoxicillin / aminopenicillins	12,867	14,040	14,706	$213,875	14,422
cefdinir / third generation cephalosporins	4,763	5,656	5,951	$123,298	5,883
amoxicillin-clavulanate / penicillins/beta-lactamase inhibitors	4,925	5,676	5,959	$120,220	5,882
prednisolone / glucocorticoids	5,132	6,078	6,076	$123,683	5,875
albuterol / adrenergic bronchodilators	12,305	12,437	13,068	$388,466	11,461
benzonatate / antitussives	795	1,092	1,311	$17,497	1,278
ibuprofen / nonsteroidal anti-inflammatory agents	6,329	6,000	6,732	$85,597	6,572
prednisone / glucocorticoids	2,962	3,404	3,316	$34,981	3,208
methylprednisolone / glucocorticoids	1,879	1,847	2,078	$27,342	2,050
albuterol-ipratropium / bronchodilator combinations	502	522	614	$48,920	567
levofloxacin / quinolones	370	374	463	$7,011	445
dexamethasone / glucocorticoids	466	500	553	$6,384	546
semaglutide / GLP-1 receptor agonists for obesity	3,391	3,126	3,474	$4,531,638	3,187
divalproex sodium / fatty acid derivative anticonvulsants	2,391	2,206	2,473	$56,846	1,971
oxycodone / narcotic analgesics	609	631	679	$21,570	632
promethazine / antihistamines	1,794	1,688	1,860	$30,189	1,677
olanzapine / atypical antipsychotics	1,459	1,369	1,522	$23,921	1,247
codeine-guaifenesin / upper respiratory combinations	62	77	119	$1,930	115
insulin lispro / insulin	832	778	888	$127,071	799
ipratropium nasal / nasal antihistamines and decongestants	270	276	325	$8,232	321
levetiracetam / pyrrolidine anticonvulsants	2,868	2,647	2,920	$73,881	2,551
budesonide / inhaled corticosteroids	1,315	1,369	1,359	$124,658	1,313
nifedipine / calcium channel blocking agents	966	891	1,004	$18,373	936

TABLE H: TOP 25 DRUG MOLECULES
BY CHANGE IN AMOUNT PAID FROM OCT 2025 TO DEC 2025 (FFS and CCOs)

Drug Molecule	Oct 2025 $ Paid	Nov 2025 $ Paid	Dec 2025 $ Paid	Dec 2025 # Claims	Dec 2025 # Unique Benes
emicizumab / factor for bleeding disorders	$1,174,324	$760,133	$1,378,096	44	30
adalimumab / TNF alpha inhibitors	$2,729,267	$2,422,257	$2,914,653	304	254
oseltamivir / neuraminidase inhibitors	$18,360	$57,010	$200,115	7,920	7,889
bimekizumab / interleukin inhibitors	$309,465	$287,457	$454,755	21	20
secukinumab / interleukin inhibitors	$268,756	$229,618	$384,911	28	26
deutivacaftor/tezacaftor/vanzacaftor / CFTR combinations	$142,078	$198,909	$255,740	9	9
semaglutide / GLP-1 receptor agonists for obesity	$4,430,981	$4,080,058	$4,531,638	3,474	3,187
fenfluramine / CNS stimulants	$200,208	$209,065	$288,285	21	17
enzalutamide / antineoplastic hormones	$125,777	$134,265	$200,864	14	13
deflazacort / glucocorticoids	$103,714	$128,294	$176,473	14	12
natalizumab / selective immunosuppressants	$97,796	$106,686	$168,920	19	14
ivosidenib / miscellaneous antineoplastics	$0	$0	$68,320	2	1
efgartigimod alfa-hyaluronidase / immune globulins	$0	$0	$66,939	1	1
canakinumab / interleukin inhibitors	$256,703	$278,087	$320,867	9	7
cenegermin ophthalmic / miscellaneous ophthalmic agents	$0	$0	$58,842	2	1
patisiran / miscellaneous metabolic agents	$0	$29,366	$58,733	2	1
glecaprevir-pibrentasvir / antiviral combinations	$64,909	$64,922	$117,627	10	9
palbociclib / CDK 4/6 inhibitors	$49,420	$65,893	$98,840	6	5
aripiprazole / atypical antipsychotics	$1,544,930	$1,409,900	$1,593,379	3,838	3,450
deutetrabenazine / VMAT2 inhibitors	$176,695	$189,023	$224,496	29	23
alpelisib / PI3K inhibitors	$90	$0	$47,718	3	2
odevixibat / miscellaneous GI agents	$45,623	$0	$91,235	1	1
treprostinil / agents for pulmonary hypertension	$70,708	$88,934	$115,842	10	8
triptorelin / antineoplastic hormones	$0	$66,927	$44,618	2	2
risperidone / atypical antipsychotics	$448,257	$404,392	$492,229	4,011	3,494

TABLE I: TOP 15 DRUG SOLID DOSAGE FORM HIGH VOLUME (100+ RX FILLS LAST MONTH) PRODUCTS WITH UNIT COST > $1
BY PERCENT CHANGE IN AMOUNT PAID PER UNIT OCT 2025 TO DEC 2025 (FFS and CCOs)

Drug Product Therapeutic Category	Dec 2025 # Claims	Dec 2025 $ Paid	Dec 2025 Avr. Paid Per Rx	Dec 2025 Avr. Units Per Rx	Oct 2025 Paid Per Unit	Nov 2025 Paid Per Unit	Dec 2025 Paid Per Unit	Percent Change
dexmethylphenidate 20 mg capsule, extended release / CNS stimulants (Y)	365	$23,245	$63.68	30	$1.58	$1.63	$1.77	11.7%
dexmethylphenidate 10 mg capsule, extended release / CNS stimulants (Y)	562	$31,044	$55.24	30	$1.38	$1.39	$1.48	7.4%
methylphenidate (30/70 release) 30 mg/24 hr capsule, extended release / CNS stimulants (Y)	110	$7,399	$67.26	30	$1.75	$1.76	$1.87	6.6%
dexmethylphenidate 25 mg capsule, extended release / CNS stimulants (Y)	212	$13,475	$63.56	30	$1.67	$1.66	$1.75	5.2%
scopolamine 1 mg/72 hr film, extended release / anticholinergics/antispasmodics	187	$9,776	$52.28	9	$4.54	$4.52	$4.74	4.3%
asenapine 5 mg tablet / atypical antipsychotics (Y)	127	$13,734	$108.14	42	$2.19	$2.23	$2.28	3.8%
Januvia (sitagliptin) (as phosphate) 100 mg tablet / dipeptidyl peptidase 4 inhibitors (Y)	181	$79,765	$440.69	41	$10.03	$10.18	$10.20	1.7%
lisdexamfetamine 10 mg capsule / CNS stimulants (Y)	122	$12,967	$106.29	30	$3.20	$3.16	$3.23	1.0%
Entresto (sacubitril-valsartan) 49 mg-51 mg tablet / angiotensin receptor blockers and neprilysin inhibitors (Y)	175	$111,067	$634.67	58	$10.78	$10.99	$10.86	0.7%
Linzess (linaclotide) 145 mcg capsule / guanylate cyclase-C agonists (Y)	289	$157,486	$544.93	30	$17.49	$17.63	$17.60	0.7%
Qelbree (viloxazine) 100 mg capsule, extended release / noradrenergic uptake inhibitors for ADHD (Y)	137	$50,492	$368.55	30	$11.90	$11.98	$11.98	0.6%
Jardiance (empagliflozin) 10 mg tablet / SGLT-2 inhibitors (Y)	573	$472,544	$824.68	41	$19.33	$19.20	$19.44	0.6%
Trintellix (vortioxetine) 20 mg tablet / miscellaneous antidepressants (Y)	106	$51,019	$481.31	29	$16.14	$16.12	$16.21	0.4%

Products are only included if 100 or more fills in last month and average cost per unit in reference month was >= $1.

TABLE I: TOP 15 DRUG SOLID DOSAGE FORM HIGH VOLUME (100+ RX FILLS LAST MONTH) PRODUCTS WITH UNIT COST > $1
BY PERCENT CHANGE IN AMOUNT PAID PER UNIT OCT 2025 TO DEC 2025 (FFS and CCOs)

Drug Product Therapeutic Category	Dec 2025 # Claims	Dec 2025 $ Paid	Dec 2025 Avr. Paid Per Rx	Dec 2025 Avr. Units Per Rx	Oct 2025 Paid Per Unit	Nov 2025 Paid Per Unit	Dec 2025 Paid Per Unit	Percent Change
Qelbree (viloxazine) 150 mg capsule, extended release / noradrenergic uptake inhibitors for ADHD (Y)	124	$72,959	$588.38	49	$11.89	$11.94	$11.94	0.4%
Farxiga (dapagliflozin) 10 mg tablet / SGLT-2 inhibitors (Y)	994	$775,655	$780.34	42	$18.57	$18.53	$18.63	0.3%

Products are only included if 100 or more fills in last month and average cost per unit in reference month was >= $1.

Prior Authorization Criteria

Calcitonin Gene-Related Peptides (CGRP) Inhibitors PA Criteria

- **AIMOVIG (erenumab-aooe)**
- **AJOVY (fremanezumab-vfrm)**
- **EMGALITY (galcanezumab-gnlm)**
- **NURTEC ODT (rimegepant)**
- **QULIPTA (atogepant)**
- **UBRELVY (ubrogepant)**
- **ZAVZPRET (zavegepant)**

Aimovig, Ajovy, Emgality, Nurtec ODT, and Qulipta are indicated for migraine *prevention*. Emgality 300mg is indicated for the treatment of *episodic cluster headache* in adults. Nurtec ODT, Ubrelvy, and Zavzpret nasal spray are indicated for *treatment of acute* migraine in adults.

Prior authorization (PA) is required for CGRP inhibitors. PA approval will be considered when the following criteria are met. Along with the Universal PA Form, please submit any supporting clinical documentation. Please also denote the indication (e.g., acute migraine treatment, episodic migraine prevention, chronic migraine prevention, episodic cluster headache treatment) for which the CGRP inhibitor is being requested.

VYEPTI (eptinezumab-jjmr) – Please see separate criteria at https://medicaid.ms.gov/pharmacy-prior-authorization/

Denial Criteria for any of the CGRP inhibitors:

- Medication will not be used within 12 weeks of last Botox administration
- Currently pregnant or nursing
- Medication Overuse Headache or Tension-Type Headache

A. Treatment of Acute Migraine

1. Initial Authorization: 6 months

Preferred Agent(s)

- Nurtec ODT 75mg once a day prn (limit 8 tablets per 31 days)
- Ubrelvy 50 or 100mg tablets once a day prn; may repeat once in 2 or more hours after first dose (limit 16 tablets per 31 days)

Criteria for Preferred Agents for Acute Migraine Treatment

1. Patient must be in the age range as recommended by FDA label**; AND**
2. Documented diagnosis of migraine**; AND**
3. Documented trial and failure of two chemically distinct triptans in the past 6 months *OR* intolerance *OR* contraindication* to triptans as documented by historical diagnosis. Please provide documentation of contraindication (e.g., ICD-10 of contraindication)**; AND**
4. No concurrent therapy with another oral CGRP agent**; AND**
5. No concurrent therapy with a strong CYP3A4 inhibitor.

* Contraindication to triptans defined as follows:

1. History of ischemic heart disease: angina pectoris, Prinzmetal's angina, or previous myocardial infarction
2. Uncontrolled hypertension: documented diagnosis, claims history of current, ongoing multi-antihypertensive treatment
3. History of cerebrovascular disease: CVA (stroke), TIA, carotid stenosis, vertebral stenosis, intracranial stenosis, aneurysm, vascular malformation, peripheral vascular disease, ischemic bowel disease.

Non-Preferred Agent(s)

- Zavzpret single 10mg dose into one nostril once a day (limit 6 doses per 31 days)

Criteria for Non-Preferred Agents for Acute Migraine Treatment

1. Documented trial and failure of Nurtec ODT AND Ubrelvy in the past 6 months; having met the criteria above**; AND**
2. No concurrent therapy with an oral CGRP agent**; AND**
3. No concurrent therapy with a strong CYP3A4 inhibitor**; AND**
4. If unable to tolerate oral medications, documented trial of sumatriptan nasal spray in the past 6 months unless triptan use is contraindicated subject to the definition detailed in above section.

2. Reauthorization: 12 months

1. Positive response to therapy demonstrated by a reduction in frequency or severity of migraines [documentation required]; **AND**
2. Patient has an overall improvement in function with therapy.

B. Prevention of Episodic or Chronic Migraine

Preferred Agents

- Aimovig 70mg/1ml subcutaneously once monthly
- Aimovig 140mg/2ml subcutaneously once monthly
- Ajovy 225mg/1.5ml subcutaneously once monthly
- Ajovy 675mg/4.5ml subcutaneously once quarterly (*3 consecutive 225mg-SC injections*)
- Emgality 240 mg/1ml subcutaneously once as loading dose* (2 consecutive 120-mg injections) followed by Emgality 120 mg subcutaneously once monthly

Non-Preferred Agents (must try and fail 2 preferred agents)

- Nurtec ODT 75mg every OTHER day (limit 16 tablets per 31 days)
- Qulipta 10, 30 or 60mg tablet once daily

* Please provide documented date of first administered dose in prescriber's office of requested medication if applicable.

Migraine Preventatives that are Not CGRPs:

The following therapies are listed in the 2024 American Headache Society's Position Statement as non-CGRP treatments to consider for episodic or chronic migraine prevention. **Providers, including those in primary care, are encouraged to utilize these prophylactic options prior to requesting CGRP therapies.**

a) Antidepressants: amitriptyline (20-50mg qhs), nortriptyline (10-100 mg qhs), duloxetine (60-120mg daily), or venlafaxine (75-150mg daily)
b) Anticonvulsants: divalproex sodium/valproate (500-1500mg daily) or topiramate (100mg daily)
c) Beta-blockers: atenolol (25-100mg daily), metoprolol (50-200mg daily), nadolol (20-240mg daily), propranolol (40-160mg daily), or timolol (10-30mg daily)
d) Angiotensin II Receptor Blockers: Candesartan (4 to 16 mg daily)
e) Chronic Migraine Only: Botulinum Toxin serotype A: *specifically* onabotulinumtoxinA (Botox®)

Prevention of Episodic or Chronic Migraine Criteria

1. Initial Authorization: 12 weeks

1. Patient must be within the age range as recommended by the FDA label**; AND**
2. Patient must meet one of the following:
    a. *For Episodic Migraine:* Documentation of at least 4, but no more than 14 migraine days per month**; or**
    b. *For Chronic Migraine:* Documentation of 15 or more headache days per month, of which at least 8 must be migraine days for at least 3 months**; AND**
3. Prescribed by or in consultation with a specialist (e.g., neurology, headache, pain)**; AND**
4. Documentation of MIDAS or HIT-6 assessment at baseline https://headaches.org/resources/headache-tests/ **; AND**
5. Documented failure of a consecutive 8-week trial at the optimal therapeutic dose as evidenced by paid pharmacy claims, *OR* intolerance *OR* contraindication, of at least ONE therapy, from any TWO of the following different therapeutic classes listed under "Migraine Preventatives that are Not CGRPs" on the previous page.
    a. For chronic migraine only, a 12-week trial of onabotulinumtoxinA, as documented by physician attestation and/or paid medical claims, may be considered as one therapy trial.
    b. At least one trial must have occurred within the past 12 months.

2. Reauthorization: 12 months

1. Positive response to therapy demonstrated by a reduction in frequency or severity of migraines [documentation required] ie. overall symptom severity (as measured by MIDAS or HIT-6) compared to baseline https://headaches.org/resources/headache-tests/ **; AND**
2. Patient has an overall improvement in function with therapy**; AND**
3. Verified pharmacy prescription claims history of previously approved agent and demonstrated adherence to monthly or quarterly fills per FDA approved dosing.

C. Treatment of Episodic Cluster Headache

Requested Product: Emgality 300 mg subcutaneously once monthly (*3 consecutive injections of 100 mg*)

Required Medical Information:

- Diagnosis of Episodic Cluster Headache
- Chart notes (documentation required upon request)
- Previous therapies tried/failed

Initial Authorization: Episodic Cluster Headache

Emgality 300 mg* *(3 consecutive injections of 100 mg)* at the onset of the cluster period, and then monthly until the end of the cluster period

* Please provide documented date of first administered dose in prescriber's office of requested medication.

1. Initial Authorization (Emgality only): 12 weeks

1. Patient must be within the age range as recommended by the FDA label**; AND**
2. Diagnosis of episodic cluster headaches**; AND**
3. At least 2 cluster periods lasting from 7 days to ≤ 1 year each and separated by pain-free remission periods of ≥ 3 months**; AND**
4. Prescribed by or in consultation with a specialist (e.g., neurology, headache, pain)**; AND**
5. Failure of verapamil at a dose of 360 mg per day, unless contraindicated or clinically significant adverse effects are experienced**; AND**
6. Emgality is not prescribed concurrently with other injectable CGRP antagonists or inhibitors**; AND**
7. Dose does not exceed 300 mg once monthly.

2. Reauthorization (Emgality only): Up to a total of 12 months per cluster period

1. Positive response to therapy demonstrated by a reduction in cluster headache attack frequency**; AND**
2. Must meet <u>one</u> of the following:
    a. Patient has not received more than 12 months of consecutive treatment**; OR**
    b. It has been at least 3 months since the patient last received Emgality**; AND**
3. Emgality is not prescribed concurrently with other injectable CGRP antagonists or inhibitors**; AND**
4. Dose does not exceed 300 mg once monthly.

New Business

Special Analysis Projects

MISSISSIPPI DIVISION OF MEDICAID

MS-DUR INTERVENTION / EDUCATIONAL INITIATIVE UPDATE

DECEMBER 2025 – FEBRUARY 2026

Ongoing Mailings:

PROVIDER SHOPPING FOR OPIOIDS (≥4 Prescribers AND ≥4 Pharmacies)				CONCOMITANT USE OF OPIOIDS AND ANTIPSYCHOTICS			SABA MONOTHERAPY		
Month	Prescribers Mailed	Pharms Mailed	Members Addressed	Month	Prescribers Mailed	Members Addressed	Month	Prescribers Mailed	Members Addressed
Mar-25	1	1	2	Mar-25	32	38	Mar-25	150	208
Apr-25	2	2	4	Apr-25	35	39	Apr-25	150	191
May-25	1	2	3	May-25	37	39	May-25	150	203
Jun-25	2	3	5	Jun-25	38	46	Jun-25	150	186
Jul-25	3	3	6	Jul-25	36	36	Jul-25	150	195
Aug-25	3	3	6	Aug-25	41	43	Aug-25	150	179
Sep-25	1	1	2	Sep-25	41	42	Sep-25	150	183
Oct-25	1	1	2	Oct-25	48	51	Oct-25	150	182
Nov-25	2	2	4	Nov-25	36	40	Nov-25	150	183
Dec-25	1	1	2	Dec-25	33	35	Dec-25	150	184
Jan-26	1	1	2	Jan-26	44	47	Jan-26	150	187
Feb-26	2	2	4	Feb-26	40	44	Feb-26	150	193

MISSISSIPPI DIVISION OF MEDICAID

MISSISSIPPI MEDICAID OPIOID OVERUTILIZATION ASSESSMENT PROGRAM

[DATE]

[PRESCRIBER'S 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 (DUR) Board has recommended several quality improvement initiatives addressing the use of opioids for the treatment of pain. The Centers for Medicare and Medicaid Services have included the use of opioids from multiple providers as one of the quality measures for adults in Medicaid programs. This measure identifies **beneficiaries without cancer who received prescriptions for opioid medications from four (4) or more prescribers and four (4) or more pharmacies.**

WHY YOU ARE RECEVING THIS LETTER

Our analysis of data from Medicaid and the Mississippi Prescription Monitoring Program for period [REPORT_START_DATE] to [REPORT_END_DATE] identified that the following beneficiary(ies) listed in the included table filled an opioid prescription written by you and met the above criteria of potential provider shopping.

WHAT WE ASK OF YOU?

Multimodal and multidisciplinary therapies can help reduce pain and improve function more effectively than single modalities. Several non-opioid pharmacologic therapies (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) are recommended first-line for chronic pain, and we encourage you to consider these options first. When you do think an opioid is appropriate, please use the Mississippi Prescription Monitoring Program to be sure the patient is not provider shopping and/or receiving too high a dose or too many opioids.

Sincerely,

Eric Pittman, PharmD
Clinical Director
MS-DUR

Terri R. Kirby, RPh, CPM
Director, Office of Pharmacy
Division of Medicaid

OPIOID UTILIZATION FOR: [BENEFICIARY NAME]			
Name of Prescriber	**Last drug prescribed**	**Date of last prescription**	**Name of Pharmacy**
[PRESCRIBER_1]	[DRUG_1]	[DATE_1]	[{JHARMACY_1]
[PRESCRIBER_2]	[DRUG_2]	[DATE_2]	[{JHARMACY_2]
[PRESCRIBER_3]	[DRUG_3]	[DATE_3]	[{JHARMACY_3]
[PRESCRIBER_4]	[DRUG_4]	[DATE_4]	[{JHARMACY_4]

{Date}

IMPORTANT INFORMATION REGARDING CONCURRENT PRESCRIBING OF OPIOIDS AND ANTIPSYCHOTICS

Dear Dr. {Prescriber Name},

In accordance with recent updates in the Centers for Medicare & Medicaid Services' (CMS) Minimum Standards in Medicaid State Drug Utilization Review (DUR), the Mississippi Division of Medicaid's DUR program has initiated a program monitoring the concurrent prescribing of opioids and antipsychotics to Medicaid beneficiaries. The intention of this review is to encourage coordination of care for beneficiaries taking antipsychotic and opioid medications concurrently.

This monitoring program is supported by the FDA's boxed warning of increased risk of respiratory and central nervous system (CNS) depression with concurrent use of opioids and CNS depressants such as antipsychotics or sedatives.[1] According to CMS, *"Patients concurrently prescribed opioid and antipsychotic drugs can benefit from increased coordination of care. Additionally, improving treatment of comorbid mental disorders is an important consideration when trying to reduce the overall negative impacts of pain. Evidence indicates that optimizing mental health and pain treatment can improve outcomes in both areas for patients seen in primary and specialty care settings. Untreated psychiatric conditions may increase the risk of both unintentional and intentional medication mismanagement, opioid use disorder, and overdose.[2] Given the intersection between psychiatric/psychological symptoms and chronic pain, it is important that the behavioral health needs of patients with pain are appropriately and carefully evaluated and treated with the concurrent physical pain problem. As such, beneficiaries who are concurrently prescribed both opioids and antipsychotics should be considered from a health system or policy perspective when addressing their treatment.[3] A patient's unique presentation and circumstances should be considered when prescribing opioids and antipsychotics."*

WHY YOU ARE RECEIVING THIS LETTER

Our analysis of prescription claims data identified the following beneficiary(ies) who filled a prescription written by you that resulted in the concurrent use of antipsychotic and opioid therapy for ≥ 14 days.

		Opioid			Antipsychotic		
Beneficiary Name	DOB	Drug Name	Date Filled	Prescriber	Drug Name	Date Filled	Prescriber

[1] Office of the Commissioner. ''Drug Safety Communications—FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning.'' *U.S. Food and Drug Administration Home Page,* Office of the Commissioner. https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-warns-about-serious-risks-and-death-when-combining-opioid-pain-or

[2] Pain Management Best Practices Inter-Agency Task Force. ''Pain Management Best Practices.'' https://www.hhs.gov/sites/default/files/ pmtf-final-report-2019-05-23.

[3] Davis, Matthew A., et al. ''Prescription Opioid Use among Adults with Mental Health Disorders in the United States.'' The Journal of the American Board of Family Medicine, vol. 30, no. 4, 2017, pp. 407–417, doi:10.3122/jabfm.2017.04.170112.

Evidence-Based DUR Initiative

WHAT WE ASK OF YOU?

When prescribing antipsychotics and opioids, ensure the coordination of care for both pain management and mental health conditions is occurring and both conditions are being appropriately treated. Optimizing both mental health and pain treatment can improve patient outcomes in both areas and minimize the risks of adverse events. Although not pain therapies, buprenorphine/naloxone products are included on the list of opioids that trigger this letter. In such cases, we are encouraging optimization of mental health treatment to support the successful management of opioid use disorder (OUD).

We want to thank you for the care you provide to Medicaid beneficiaries. If we can be of any assistance, please do not hesitate to contact us.

Sincerely,

Terri R. Kirby, RPh, CPM
Director, Office of Pharmacy
Mississippi Division of Medicaid

Eric Pittman, PharmD
Project Director
MS-DUR

{Date}

IMPORTANT INFORMATION REGARDING THE TREATMENT OF ASTHMA

Dear Dr. {Prescriber Name},

The 2024 Global Initiative for Asthma (GINA) report provides recommendations for the management of asthma across various age groups.[1] In recent years, asthma treatment guidelines have been updated to reflect a shift away from the use of short-acting beta-agonists (SABA) as monotherapy in asthma patients due to increased risks of adverse events. The use of 3 or more SABA inhalers per year is associated with a higher risk of severe exacerbations, while the use of 12 or more SABA inhalers per year is associated with a higher risk of asthma-related death.[1] Conversely, the use of inhaled corticosteroids (ICS) has been shown to significantly reduce the risks of adverse events such as emergency department visits, hospitalizations, and death.[2] In general, maintenance and reliever therapy (MART) or single-inhaler maintenance and reliever therapy (SMART) with an ICS-containing product is recommended as initial therapy for most individuals with asthma ages 6 years and above. Specifically, guidelines recommend the use of a single combination agent containing a low-dose ICS and the long-acting beta-agonist formoterol.[1]

Recently, Medicaid's Drug Utilization Review Board affirmed their support for the use of ICS/formoterol products as both maintenance and reliever therapy for the treatment of asthma. To make it easier to prescribe SMART for Medicaid beneficiaries, we have included a table listing products that are preferred and available without prior authorization for both maintenance and reliever use.

Drug	Strength	PDL Status
Symbicort (budesonide/formoterol)	80mcg/4.5mcg 160mcg/4.5mcg	Preferred
Dulera (mometasone/formoterol)	50mcg/5mcg 100mcg/5mcg 200mcg/5mcg	Preferred

We examined the use of ICS-containing products among members 6 years and older with an asthma diagnosis and a history of 3 or more SABA fills in the previous six months. Our analysis of Medicaid claims data revealed that **56.9%** of members received only SABA inhalers for the treatment of their asthma. This indicates SABA monotherapy in a majority of members being treated for asthma for whom guidelines recommend the use of an ICS-containing product.

WHY YOU ARE RECEIVING THIS LETTER?

You have been identified as an outlier in our analysis. During our most recent analysis, we identified Medicaid members under your care who were 6 years and older with an asthma diagnosis who received 3 or more SABA inhalers in the previous 6 months with no pharmacy claims for ICS-containing medications. In this six-month period, you are in the lowest quartile of providers examined estimated based on the proportion of members you have prescribed SABA to who also received ICS. See figure below:

Your performance compared to your peers

$$\text{Rate of ICS therapy in conjunction with SABA use} = \frac{\text{Members with SABA \& ICS use}}{\text{Members prescribed SABA inhalers}}$$

[1] Global Initiative for Asthma, 2024. Global Initiative for Asthma - GINA. Accessed June 3, 2024. https://ginasthma.org/

[2] Crossingham I, Turner S, Ramakrishnan S, et al. Combination fixed-dose beta agonist and steroid inhaler as required for adults or children with mild asthma. *Cochrane Database Syst Rev*. 2021;5(5):CD013518. doi:10.1002/14651858.CD013518.pub2

The following Medicaid member(s) under your care were identified as receiving 3 or more SABA inhalers in the previous 6 months and did not have any pharmacy claims for ICS-containing medications.

INSERT TABLE IDENTIFYING MEMBER(S)

OUR GOAL FOR ASTHMA PATIENTS

Medicaid is looking to improve the health of individuals experiencing asthma. We support the use of ICS-containing products, specifically ICS/formoterol products, in the treatment of asthma and encourage providers to engage in shared clinical decision-making discussions with eligible members. We want to thank you for the care you provide to Medicaid members. If we can be of any assistance, please do not hesitate to contact us.

Sincerely,

Terri R. Kirby, RPh, CPM
Director, Office of Pharmacy
Mississippi Division of Medicaid

Eric Pittman, PharmD, PhD
Project Director, MS-DUR
University of Mississippi School of Pharmacy

HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIRETROVIRAL THERAPY ADHERENCE TRAJECTORY MODELING

BACKGROUND

The crucial role of adherence to human immunodeficiency virus (HIV) antiretroviral therapy (ART) in achieving viral load suppression is well documented. Lack of adherence may result in treatment failure, increased viral transmission, increased drug resistance, increased costs of care, and poorer outcomes.

At the December 2025 DUR Board meeting, a report describing ART adherence among Medicaid members revealed that only 34.87% of members had a proportion of days covered (PDC) greater than 90% during calendar year 2024.[1] As a follow-up to that report, this study aims to define HIV ART adherence groups within a cohort and identify predictors of adherence trajectories.

METHODS

Study Design and Data Source

This observational analysis utilized Mississippi Medicaid administrative claims data from January 2021 to December 2025. The dataset included claims from both the Fee-for-Service (FFS) program and Coordinated Care Organizations (CCOs), to include Magnolia Health (MAG), Molina Healthcare (MOL), UnitedHealthcare (UHC), and TrueCare (TRU). Pharmacy claims were used to identify all initiations of HIV ART during the study period.

Study Population

HIV ART initiators were identified between January 1, 2022, and December 31, 2024. HIV ART drug regimen criteria followed specifications for the Pharmacy Quality Alliance (PQA) Proportion of Days Covered: Antiretroviral Medications (PDC-ARV) measure.[2] Members with 3 or more distinct ARV medications (each with 2 or more fill dates) or a Food and Drug Administration (FDA)-approved 2-drug regimen (dolutegravir plus lamivudine, or dolutegravir plus rilpivirine with 2 or more fill dates) were included. The first prescription fill for HIV ART was defined as the index date. A washout period (no ART claims in the 90 days prior to the index date) was required to establish initiators. The cohort was restricted to members age less than 65 years at their index date and excluded anyone with a hospice encounter during the study window. Each member was required to have continuous enrollment in Mississippi Medicaid during the 6-month period before the index date (baseline period) and the 12-month period after the index date (follow-up period). Members who died during the 12-month follow-up period were excluded.

For trajectory modeling, HIV ART adherence was measured using the monthly proportion of days covered (PDC) during the 12-month follow-up period. PDC, a frequently used adherence metric, is defined as the ratio of total days covered by a medication (based on days' supply) to the total days in the observation period. Group-based trajectory modeling (GBTM) was employed to categorize individuals based on distinct adherence trends. The model input was monthly PDC values during

the 12-month follow-up period following the index date. For the estimation of model parameters, GBTM used maximum likelihood estimation. The final trajectory model was selected from 3 to 5 adherence groups based on Bayesian information criteria, clinical significance, and group size adequacy (a sample size of 5% membership requirement). Each member was assigned to their most likely trajectory group.

Covariates

Several characteristics were measured in the study to better understand medication utilization patterns. Demographic characteristics included age, sex, race, and health plan. Age and health plan were assessed as of the index date. Comorbidity measures in the model included Charlson Comorbidity Index (CCI)[3], mental health disorder flags, substance use disorder flags, and obesity flags using diagnosis codes from the 6-month pre-index period. Pill burden was also included as a covariate in the model. Pill burden was calculated at the index date as the submitted quantity divided by days' supply. Values of 1 or less were classified as single tablet regimen (STR) and values greater than 1 as a multi-tablet regimen (MTR).

Statistical Analysis

Descriptive statistics were performed to summarize member demographic and clinical characteristics. Univariate risk factor analyses were conducted by entering each covariate (sex, age, race, health plan, CCI, mental health disorder, substance use disorder, obesity, and pill burden) into the GBTM model one at a time. A multinomial logistic regression model was used to identify predictors of adherence trajectories to HIV ART in the cohort, with the consistent adherence group as the reference category.

RESULTS

Of the 733 Medicaid members who initiated HIV ART therapy between January 1, 2022, and December 31, 2024, 519 met inclusion criteria for the study cohort (Table 1).

TABLE 1. Attrition Table for Final Cohort

Step Number	Step Description	Number of Members
1	All members with any ART claim (2021-2025)	2,958
2	Met drug regimen criteria (>=3 ARTs or FDA-approved 2-drug regimen)	1,793
3	Index date (first ART fill) between Jan 2022 - Dec 2024 with a 3-month washout	733
4	Age < 65; at index date	728
5	Hospice exclusion	715
6	6-month pre-index continuous enrollment	593
7	12-month post-index continuous enrollment	523
8	After excluding deaths during 12-month post-index follow-up	519
9	**Final analytic cohort**	**519**

Notes: ART - antiretroviral therapy, FDA - Food and Drug Adminstration

Using HIV ART adherence calculations during the 12-month follow-up period and GBTM, a 4-group model was selected as the best fit. Four distinct groups were identified: early discontinuation (Group 1 – 20.0%), inconsistent adherence (Group 2 – 31.6%), early adherence/steady decline (Group 3 – 16.0%), and consistent adherence (Group 4 – 32.4%) (Figure 1).

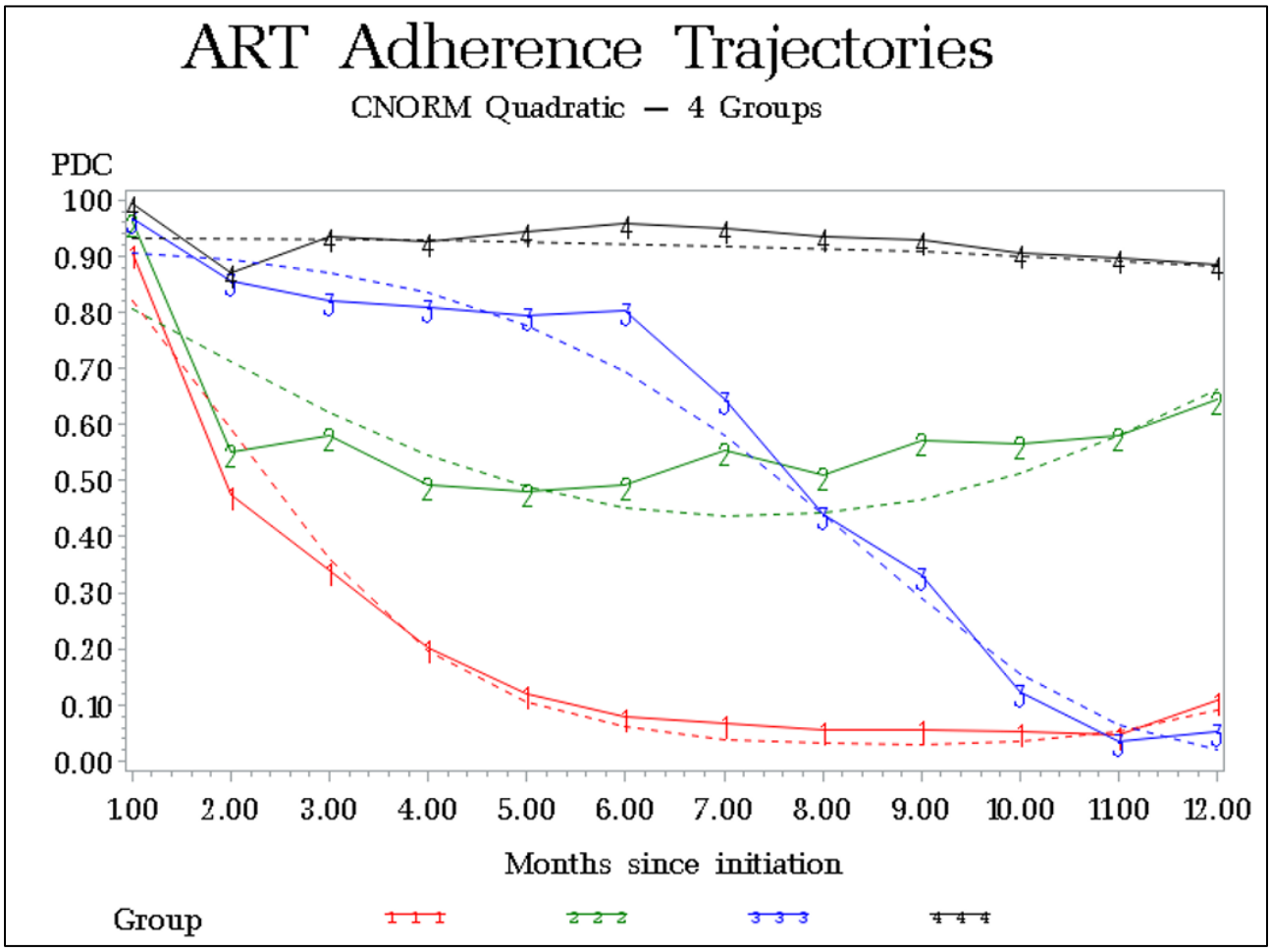

FIGURE 1. HIV ART Adherence Trajectories in 12-month Follow-up

Table 2 displays the descriptive characteristics for the entire study cohort and for each trajectory group. The mean age across all groups was 39.4 years, however, the mean age in the early discontinuation group was younger than the other groups at 34.9 years. The majority of the full study cohort was female, however, males made up a slight majority in the adherence group. Most members were Black, enrolled in managed care, and were on a single tablet regimen. Regarding comorbidities, most had a CCI value equal to zero and were not diagnosed with a mental health disorder, substance use disorder, or obesity.

TABLE 2. Baseline Demographic and Clinical Characteristics Among ART Initiators by Adherence Trajectory Group January 1, 2022 - December 31, 2024

Baseline Characteristic	Total Cohort (N = 519, 100%)	Early Discontinuation (Group 1, n = 104, 20.04%)	Inconsistent Adherence (Group 2, n = 164, 31.60%)	Early Adherence / Steady Decline (Group 3, n = 83, 15.99%)	Consistent Adherence (Group 4, n = 168, 32.37%)
12-Month PDC, mean (SD)	0.61 (0.28)	0.20 (0.09)	0.58 (0.15)	0.55 (0.13)	0.93 (0.07)
Age categories					
Age, mean (SD)	39.37 (13.56)	34.85 (13.12)	40.29 (12.98)	40.37 (13.23)	40.76 (14.06)
≤35 years	218 (42.00%)	59 (56.73%)	66 (40.24%)	29 (34.94%)	64 (38.10%)
36 – 50 years	164 (31.60%)	30 (28.85%)	49 (29.88%)	32 (38.55%)	53 (31.55%)
51 – 65 years (reference)	137 (26.40%)	15 (14.42%)	49 (29.88%)	22 (26.51%)	51 (30.36%)
Sex					
Male (reference)	249 (47.98%)	46 (44.23%)	80 (48.78%)	34 (40.96%)	89 (52.98%)
Female	270 (52.02%)	58 (55.77%)	84 (51.22%)	49 (59.04%)	79 (47.02%)
Race					
White (reference)	58 (11.18%)	8 (7.69%)	17 (10.37%)	12 (14.46%)	21 (12.50%)
Black	328 (63.20%)	72 (69.23%)	99 (60.37%)	52 (62.65%)	105 (62.50%)
Other race	133 (25.63%)	24 (23.08%)	48 (29.27%)	19 (22.89%)	42 (25.00%)
Plan Type					
Fee-for-service (reference)	179 (34.49%)	40 (38.46%)	56 (34.15%)	32 (38.55%)	51 (30.36%)
Managed care	340 (65.51%)	64 (61.54%)	108 (65.85%)	51 (61.45%)	117 (69.64%)
CCI categories					
Charlson Comorbidity Index (CCI), mean (SD)	0.82 (1.54)	0.64 (1.26)	0.80 (1.60)	0.95 (1.74)	0.89 (1.54)
CCI = 0 (reference)	326 (62.81%)	70 (67.31%)	104 (63.41%)	52 (62.65%)	100 (59.52%)
CCI 1 – 2	138 (26.59%)	26 (25.00%)	44 (26.83%)	19 (22.89%)	49 (29.17%)
CCI ≥ 3	55 (10.60%)	8 (7.69%)	16 (9.76%)	12 (14.46%)	19 (11.31%)
Mental Health Disorder					
No (reference)	347 (66.86%)	72 (69.23%)	110 (67.07%)	54 (65.06%)	111 (66.07%)
Yes	172 (33.14%)	32 (30.77%)	54 (32.93%)	29 (34.94%)	57 (33.93%)
Substance Use Disorder					
No (reference)	367 (70.71%)	71 (68.27%)	113 (68.90%)	63 (75.90%)	120 (71.43%)
Yes	152 (29.29%)	33 (31.73%)	51 (31.10%)	20 (24.10%)	48 (28.57%)
Obesity					
No (reference)	431 (83.04%)	91 (87.50%)	135 (82.32%)	68 (81.93%)	137 (81.55%)
Yes	88 (16.96%)	13 (12.50%)	29 (17.68%)	15 (18.07%)	31 (18.45%)
Pill Burden					
Single tablet regimen (reference)	500 (96.34%)	92 (88.46%)	162 (98.78%)	81 (97.59%)	165 (98.21%)
Multi-tablet regimen	19 (3.66%)	12 (11.54%)	2 (1.22%)	2 (2.41%)	3 (1.79%)

Values reported as n (column %) for categorical variables and mean (SD) for continuous variables. ART = Antiretroviral Therapy; CCI = Charlson Comorbidity Index; PDC = Proportion of Days Covered.

Table 3 presents multinomial logistic regression analysis results examining factors associated with being in the consistent adherence trajectory group. Relative to the consistent adherence group, being in a younger age group (≤ 35 years; OR = 3.460, 95% CI = 1.739-6.886) and being on a multi-tablet regimen (OR = 7.722, 95% CI 2.145-27.801) were significantly associated with greater odds of belonging to the early discontinuation group. While no other factors were significantly associated with belonging to the consistent adherence group compared to the other groups, sample size likely impacted the findings.

TABLE 3. Univariate Associations Between Baseline Characteristics and Antiretroviral Therapy Adherence Trajectory Group Membership

Baseline Characteristic	Early Discontinuation (Group 1) vs. Consistent Adherence			Inconsistent Adherence (Group 2) vs. Consistent Adherence			Early Adherence / Steady Decline (Group 3) vs. Consistent Adherence		
	OR	95% CI	p-value	OR	95% CI	p-value	OR	95% CI	p-value
Sex									
Male (reference)	*Reference*			*Reference*			*Reference*		
Female	1.420	0.869 – 2.322	0.162	1.183	0.769 – 1.820	0.445	1.624	0.954 – 2.764	0.074
Age category									
51 – 65 years (reference)	*Reference*			*Reference*			*Reference*		
≤35 years	**3.460**	**1.739 – 6.883**	**< 0.001**	0.980	0.582 – 1.652	0.941	0.994	0.509 – 1.943	0.987
36 – 50 years	2.021	0.962 – 4.249	0.063	0.906	0.523 – 1.572	0.726	1.372	0.705 – 2.672	0.352
Race									
White (reference)	*Reference*			*Reference*			*Reference*		
Black	1.937	0.818 – 4.587	0.133	1.355	0.665 – 2.762	0.403	0.838	0.391 – 1.795	0.649
Other race	1.571	0.606 – 4.069	0.353	1.676	0.771 – 3.642	0.192	0.765	0.319 – 1.834	0.549
Plan Type									
Fee-for-service (reference)	*Reference*			*Reference*			*Reference*		
Managed care	0.680	0.408 – 1.135	0.140	0.856	0.539 – 1.359	0.509	0.695	0.400 – 1.205	0.195
Charlson Comorbidity Index									
CCI = 0 (reference)	*Reference*			*Reference*			*Reference*		
CCI 1 – 2	0.730	0.415 – 1.283	0.273	0.883	0.541 – 1.441	0.618	0.699	0.370 – 1.321	0.271
CCI ≥ 3	0.579	0.240 – 1.396	0.224	0.809	0.394 – 1.663	0.565	1.203	0.542 – 2.669	0.650
Mental Health Disorder									
No (reference)	*Reference*			*Reference*			*Reference*		
Yes	0.865	0.512 – 1.463	0.590	0.956	0.606 – 1.509	0.847	1.046	0.602 – 1.818	0.874
Substance Use Disorder									
No (reference)	*Reference*			*Reference*			*Reference*		
Yes	1.259	0.743 – 2.132	0.392	1.198	0.749 – 1.915	0.452	0.689	0.366 – 1.297	0.249
Obesity									
No (reference)	*Reference*			*Reference*			*Reference*		
Yes	0.583	0.284 – 1.194	0.140	0.982	0.564 – 1.711	0.949	0.975	0.493 – 1.927	0.942
Pill Burden									
Single tablet regimen (reference)	*Reference*			*Reference*			*Reference*		
Multi-tablet regimen†	**7.722**	**2.145 – 27.801**	**0.002**	0.671	0.111 – 4.066	0.664	0.675	0.069 – 6.588	0.735

OR = Odds Ratio; CI = Confidence Interval. Bold p-values indicate statistical significance (p < 0.05). Reference group for all comparisons: Consistent Adherence (Group 4). All models estimated using multinomial generalized logit regression (PROC LOGISTIC, SAS).

† Multi-tablet regimen (MTR) estimates for Groups 2 and 3 should be interpreted with caution; 25% of cells had expected counts < 5 in the chi-square test, indicating small cell sizes.

CONCLUSIONS

Adherence to HIV antiretroviral therapy is key to attaining viral suppression and the long-term goal of eliminating HIV in the U.S. Although GBTM revealed 4 distinct adherence groups, few factors were identified that predicted members with being in the consistent adherence trajectory group compared to other groups. These findings point to the need for DOM to engage in broad efforts in increase HIV ART adherence among Medicaid members.

RECOMMENDATIONS

Affirm DUR recommendations from the December 2025 DUR Board meeting:

1. DOM should collaborate with Mississippi State Department of Health, infectious disease practice groups, and state medical/pharmacy/nursing associations on strategies to improve ART adherence among Medicaid members.

2. DOM should conduct targeted outreach to providers with members who have low ART adherence.

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APPROPRIATE PRESCRIBING OF ANTIPSYCHOTICS FOR MEDICAID MEMBERS IN LONG-TERM CARE

BACKGROUND

Monitoring the appropriate prescribing of antipsychotic medications in long-term care (LTC) and other institutional settings is an important patient safety and quality-of-care priority. Antipsychotic medications are effective for the treatment of conditions such as schizophrenia and bipolar disorder; however, concerns about inappropriate prescribing among vulnerable populations have led to increased federal oversight. The Consolidated Appropriations Act, 2024 expanded existing Medicaid drug utilization review (DUR) requirements by directing state Medicaid programs to monitor antipsychotic medication utilization among individuals aged 18 years and older residing in institutional care settings. These settings include nursing facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases, inpatient psychiatric hospitals, and other institutional care environments. Beginning in 2026, state Medicaid programs must report these data to the Centers for Medicare & Medicaid Services (CMS) as part of the annual Medicaid DUR reporting process, reflecting increased federal attention to appropriate psychotropic medication use among institutionalized adult populations.[1]

Oversight of antipsychotic prescribing is important. While antipsychotic medications play a crucial pharmacotherapeutic role in the treatment of many conditions, their inappropriate use to sedate or control disruptive behaviors in LTC settings is well documented.[2] In addition to concerns regarding misuse, antipsychotic medications are associated with clinically significant adverse effects that require careful monitoring. Both first- and second-generation antipsychotics can contribute to metabolic complications including weight gain, insulin resistance, hyperglycemia, and dyslipidemia, which collectively increase the risk of metabolic syndrome, type 2 diabetes mellitus, and cardiovascular disease. These risks are particularly concerning in institutionalized populations, who often have multiple chronic conditions and limited ability to communicate adverse symptoms. For these reasons, systematic monitoring of antipsychotic utilization through Medicaid DUR programs and other quality initiatives is essential to promote appropriate prescribing, reduce avoidable harm, and improve the quality of care for individuals residing in long-term and other institutional care settings.[3]

This project serves as a baseline assessment describing the appropriateness of antipsychotic use among Medicaid members enrolled in LTC settings. Medicaid members enrolled in LTC who received antipsychotic medications were evaluated on three metrics: the use of multiple antipsychotic medications concurrently, the presence of appropriate clinical indications for use, and the completion of routine metabolic monitoring.

METHODS

A retrospective analysis was conducted using Mississippi Medicaid pharmacy and medical claims for fee-for-service (FFS) and coordinated care organizations [UnitedHealthcare (UHC), Magnolia

Health (MAG), Molina Healthcare (MOL), TrueCare (TRU)] for the period of January 1, 2022, to December 31, 2025. Pharmacy point-of-sale (POS) claims for antipsychotic (AP) medications (see Supplemental Table 1) among Medicaid members with at least one month of enrollment in a long-term care (LTC) setting during the study period were identified. For each prescription claim, the fill date was mapped to the member's LTC enrollment status for the corresponding month to determine whether the AP claim overlapped with an active LTC stay. The index prescription claim was defined as the first observed AP claim with overlapping LTC enrollment. For each AP claim that was found to overlap with LTC enrollment, three metrics were evaluated: the use of multiple antipsychotics concurrently, the presence of an appropriate clinical diagnosis, and the completion of recommended metabolic monitoring.

To determine the concurrent use of multiple AP medications, the cumulative number of overlapping days between two or more distinct antipsychotic agents within a ±90-day window surrounding the index prescription claim was calculated. Overlap was defined as the number of days during which the supply of at least two distinct AP medications coincided. Concurrent AP use for 30, 60, and 90 days was determined.

To identify the presence of an appropriate clinical diagnosis, claims data in the 12-month period prior to the index prescription claim through one month after the index prescription claim were assessed for International Classification of Diseases, 10th Revision (ICD-10) codes matching appropriate clinical diagnoses. Appropriate clinical diagnoses included those matching U.S. Food and Drug Administration (FDA)-approved indications for AP medications or those associated with conditions where the use of AP medication is supported by clinical evidence. Appropriate diagnoses were categorized into two groups – primary or secondary. Primary diagnoses included schizophrenia, bipolar 1 disorder, Tourette's syndrome, Huntington's disease, and major depressive disorder. Secondary diagnoses, where evidence supports the use of antipsychotics, included autism spectrum disorder, Parkinson's disease psychosis, agitation associated with neurocognitive disorders, anxiety disorders (including obsessive-compulsive disorder), bipolar II disorder, agitation, chronic depression, serotonin syndrome, suicidal ideation, intractable hiccups, acute intermittent porphyria, nausea, and vomiting (see Supplemental Table 2). Claims without a diagnosis for any of the listed conditions during the identification window were flagged as lacking an appropriate diagnosis.

For the presence of metabolic monitoring, claims for blood glucose tests (including blood glucose or hemoglobin A1c [HbA1c]) and cholesterol tests (including cholesterol or low-density lipoprotein cholesterol [LDL-C]) in the 12-month period prior to the index prescription claim through one month after the index prescription claim were assessed.

All data were converted to member-level data and reported.

RESULTS

Between January 2022 and December 2025, 3,803 Medicaid members had at least one AP prescription claim during a LTC stay (Table 1). Among those members, the majority were male, under the age of 18 years, and enrolled in FFS. Collectively, these members accounted for 90,949 AP prescription claims during the study period.

TABLE 1. Characteristics of Medicaid Members with AP Claims while Enrolled in LTC, January 2022 - December 2025

	N	%
Total members	**3,803**	
Gender		
Male	2,214	58.22
Female	1,589	41.78
Age (years)		
17 and lower	2,038	53.59
18-35	399	10.49
36 to 50	300	7.89
51 to 65	980	25.77
66 and above	86	2.26
Race		
White	1,712	45.02
Black	1,730	45.49
Other	361	9.49
Plan		
FFS	2,017	53.04
MAG	911	23.95
MOL	373	9.81
TRU	107	2.81
UHC	395	10.39

Note: FFS - fee-for-service; MAG - Magnolia Health; MOL - Molina Healthcare; TRU - TrueCare; UHC - UnitedHealthcare; LTC - Long-term Care; AP - antipsychotic. Demographic characteristics (age and plan enrollment) were evaluated as of the last active month of LTC with an active AP use.

Antipsychotic polypharmacy can increase an individual's chances of experiencing side effects and increase the costs of treatment with limited evidence supporting improved efficacy over monotherapy.[4] While the concurrent use of multiple antipsychotics may be necessary to treat certain clinical conditions, use should be monitored for appropriateness. Mississippi Medicaid has established prior authorization criteria to verify that the use of two or more antipsychotics in members younger than 18 years is supported by medical necessity.[5] Currently, these criteria do not apply to individuals 18 years and older.

Among the 3,803 members prescribed antipsychotics in an LTC setting, 21.2% had concurrent use of at least 30 days with two or more distinct AP medications (Table 2). Examining concurrent use further, 15.5% had at least 60 days of concurrent use and 12.4% had 90 days of concurrent use (Table 2.1).

TABLE 2. Concurrent use of Multiple AP Medications among Medicaid Members Enrolled in LTC, January 2022 to Decembrer 2025

	N	%
Total members	**3,803**	
Any concurrent use*		
Yes	806	21.19
No	2,997	78.81

Notes: LTC - Long-term Care; AP - antipsychotic
**Any concurrent use refers to the use of multiple AP medications in either 30, 60, or 90 days.*

TABLE 2.1. Concurrent use of Multiple AP Medications among Medicaid Members Enrolled in LTC by Number of Concurrent Days, January 2022 to December 2025

	N	%
Total Members	**3,803**	
Concurrent use for 30-days		
Yes	806	21.19
No	2,997	78.81
Concurrent use for 60-days		
Yes	585	15.38
No	3,218	84.62
Concurrent use for 90-days		
Yes	473	12.44
No	3,330	87.56

Notes: LTC - Long-term Care; AP - antipsychotic

The assessment of supported indications can be complex. FDA-approved indications and many evidence-based indications were included in this analysis. While this list is not exhaustive, a broad list of conditions was developed based on clinical consultation and other state guidelines.[6] Of the 3,803 members included in the analysis, 79.3% (3,016) had a diagnosis consistent with a primary indication in claims data during the observation period (12 months prior to the index prescription claim through one month after the index prescription claim). An additional 19.2% (730) had a secondary indication present in claims data. Only 1.5% (57) of members with AP use while in LTC did not have an evidence-based diagnosis present in claims data during the observation period.

TABLE 3. Appropriate Clinical Diagnosis Among Medicaid Members in LTC Prescribed APs, January 2022 to December 2025

	N	%
Total Members	**3,803**	
Any evidence-based diagnosis present*	3,746	98.5
No evidence-based diagnosis present*	57	1.5

Notes: LTC - long-term care; APs - antipsychotics
**Evidence-based indications include diagnoses for Tourette's syndrome, Huntington's disease, bipolar I disorder, major depressive disorder, schizophrenia, autism, anxiety disorders, Parkinson's disease, major neurocognitive disease with agitation, chronic depression, psychosis, delirium, agitation, nausea/vomiting, intractable hiccups, bipolar II disorder, serotonin syndrome, and suicidal ideation.*

TABLE 3.1. Medicaid Members with a Diagnosis for a Primary Indication, January 2022 to December 2025

	N	%
Total Members	**3,803**	
Diagnosis for a primary indication present*	3,016	79.28
No diagnosis for a primary indication present*	787	20.72

Notes: LTC - long-term care
**Primary indicated conditions include diagnoses for Tourette's syndrome, Huntington's disease, bipolar I disorder, major depressive disorder, and schizophrenia.*

TABLE 3.2. Medicaid Members with a Diagnosis for a Secondary Indication, January 2022 to December 2025

Members without a Primary Indication	N	%
	787	
Diagnosis for a secondary indication present*	730	92.76
No diagnosis for a secondary indication present*	57	7.24

**Secondary indicated conditions include diagnoses for autism, anxiety disorders, Parkinson's disease, major neurocognitive disease with agitation, chronic depression, psychosis, delirium, agitation, intractable hiccups, bipolar II disorder nausea/vomiting, serotonin syndrome, and suicidal ideation.*

Antipsychotic medications have been associated with a range of metabolic side effects that include weight gain, glycemic dysfunction, and dyslipidemia.[3] Current clinical guidance recommends routine metabolic monitoring for individuals prescribed antipsychotic medications at baseline, during the initial phase of treatment, and annually. The Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) is part of the Medicaid Child Core Set that states report annually to CMS.[7] The measure assesses the percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing during the measurement year. While this quality measure is designed for children and adolescents, a similar methodology was utilized in this study.

For this analysis, metabolic monitoring for glucose and cholesterol testing was determined during the 12 months prior to the index prescription claim through one month after the index prescription claim. During this observation period, 90.8% (3,453) of the 3,803 members included in the analysis had an associated blood glucose test and 78.3% (2,979) had an associated

cholesterol test. A total of 77.8% (2,960) had both blood glucose and cholesterol tests during the observation period (Table 4). While monitoring cholesterol and blood glucose levels once in a 12-month period does not cover all recommended metabolic monitoring, this can be considered a minimum for appropriate metabolic monitoring.

TABLE 4. Metabolic Monitoring Among Medicaid Members in LTC Prescribed APs, January 2022 to December 2025

	N	%
Total Members	**3,803**	
Blood glucose tests		
Yes	3,453	90.8
No	350	9.2
Cholesterol tests		
Yes	2,979	78.33
No	824	21.67
Both tests		
Yes	2,960	77.83
No	843	22.17

Notes: LTC - Long-term Care; AP - antipsychotic
Blood glucose tests include blood glucose and hemoglobin A1c tests.
Cholesterol tests include total cholesterol and low-density lipoprotein cholesterol tests.

CONCLUSIONS

While antipsychotic medications are vital for the treatment of several conditions, the use of these medications should be monitored to reduce side effects and ensure appropriateness of care, particularly among individuals residing in long-term care facilities. This project demonstrated that most Medicaid members taking antipsychotics while enrolled in long-term care were not concurrently prescribed multiple antipsychotics, had an appropriate diagnosis in claims data supporting the use of these medications, and had timely metabolic monitoring. In compliance with CMS's new requirements for reporting, monitoring of antipsychotic medication use in the long-term care population will continue.

RECOMMENDATIONS

1. MS-DUR will begin quarterly monitoring of the appropriateness of antipsychotic medication use among adults in LTC facilities.
2. Input from the Board is sought regarding potential interventions or outreach resulting from this report.

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SUPPLEMENTAL TABLE 1. Antipsychotic Medication Included in Analysis	
Drug Class	**Generic Name**
Anitpsychotic Medications	aripiprazole, asenapine, brexpiprazole, cariprazine, chlorpromazine, clozapine, dexmedetomidine, fluphenazine, haloperidol, iloperidone, loxapine, lumateperone, lurasidone, molindone, olanzapine, paliperidone, perphenazine, pimavanserin, quetiapine, risperidone, thioridazine, trifluoperazine, xanomeline/trospium, ziprasidone
Source: 2026 Universal Preferred Drug List (Mississippi Medicaid)	

SUPPPLEMENTAL TABLE 1. Appropriate Diagnoses for AP Therapy	
Diagnosis Condition	**ICD-10 Codes**
Schizophrenia	F20, F25, F20.0, F20.1, F20.2, F20.3, F20.5, F20.8, F20.9, F25.0, F25.1, F25.8, F25.9, F20.81, F20.89
Tourette's Syndrome	F92.5, F95.2
Huntington's Disease	G10
Bipolar I Disorder	F31, F31.0, F31.1, F31.2, F31.3, F31.4, F31.5, F31.6, F31.7, F31.10, F31.11, F31.13, F31.30, F31.31, F31.32, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78
Bipolar II Disorder	F31.81
Acute Mania	F30

Major Depressive Disorder	F32, F33, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.4, F33.9, F33.40, F33.41, F33.42
Chronic Depression	F34.1
Psychosis	F23, F24, F29, R44.0, F60.0
Delirium	F05
Autism Spectrum Disorder	F84.0, F84.3, F84.5, F84.8, F84.9
Anxiety Disorders	F42, F99, F06.4, F40.8, F40.9, F41.0, F41.1, F41.3, F41.8, F41.9, F42.2, F42.3, F42.4, F42.8, F42.9, F43.0, F44.9, F45.8, F48.8, F48.9, F93.8, R45.2, R45.5, R45.6, R45.7, F40.00, F40.01, F40.02, F40.10, F40.11, F43.10, F43.11, F43.12, F40.210, F40.218, F40.220, F40.228, F40.230, F40.231, F40.232, F40.233, F40.240, F40.241, F40.242, F40.243, F40.248, F40.290, F40.291, F40.298
Parkinson's Disease	G20, G20.C, G21.3, G21.4, G21.8, G21.9, G20.A1, G20.A2, G20.B1, G20.B2, G21.11, G21.19, G31.83
Major Neurocognitive Disorder with Agitation	F01.511, F01.A11, F01.B11, F01.C11, F02.811, F02.A11, F02.B11, F02.C11, F03.911, F03.A11, F03.B11, F03.C11
Severe Agitation	R45.1, R45.4, R45.5, R45.6, F91.1, F91.2
Acute Intermittent Porphyria	E80.21
Intractable Hiccups	R06.6
Nausea and Vomiting	R11.0, R11.2, R11.10

Serotonin Syndrome	G90.81
Suicidal Ideation	R45.851
Adjunctive Therapy for Depression	Z79.899

AP - antipsychotic

UPDATED COMPLIANCE MEASUREMENTS FOR INITIATORS OF GLP-1 ANTI-OBESITY MEDICATIONS

BACKGROUND

Mississippi Medicaid began coverage of select glucagon-like peptide 1 receptor agonists (GLP-1 RAs) for obesity management in July 2023. Since that time, MS-DUR has presented multiple reports examining uptake trends, characteristics of initiators, compliance measurements, and preliminary outcomes assessments.[1] As coverage continues, updated or expanded research projects will follow. At the March 2025 Drug Utilization Review (DUR) Board meeting, MS-DUR presented an analysis estimating compliance metrics among Mississippi Medicaid members who initiated GLP-1 RA anti-obesity medications (AOMs) from July 2023 through December 2023, a period during which national drug shortages affected product availability.

The present study builds on this earlier work by estimating compliance metrics for members initiating GLP-1 RA AOMs through July 2025, including a period in which GLP-1 RA supply constraints were no longer a significant issue.

METHODS

Study Design and Data Source

This observational study utilized Mississippi Medicaid administrative claims data from January 2023 through December 2025. The dataset included claims from both the Fee-for-Service (FFS) program and all Managed Care Organizations (MCOs), including Magnolia Health (MAG), Molina Healthcare (MOL), and UnitedHealthcare (UHC). Pharmacy claims were used to identify all initiations of GLP-1 RA AOMs during the study period.

Study Population

GLP-1 RA AOM initiators were identified between July 1, 2023, and June 30, 2025. The first prescription fill for a GLP-1 RA AOM during this period was defined as the index date. Members were required to be at least 18 years old and have continuous Medicaid enrollment during the 6-month baseline period prior to the index date. Members who initiated GLP-1 RA AOMs through December 31, 2024 were required to have continuous enrollment during the 12-month follow-up period after the index date, while those initiating between January 1, 2025 and June 30, 2025 were required to have continuous enrollment during the 6-month follow-up period after the index date.

Outcomes

Compliance measures included adherence, persistence, discontinuation, and reinitiation, assessed at 3-month, 6-month, and 12-month intervals* during 3 initiation periods (Period 1: July 2023 – December 2023; Period 2: January 2024 – December 2024; Period 3: January 2025 – June 2025).

- **Adherence rate** was defined as the proportion of members with a proportion of days covered (PDC) of at least 80% of days.
- **Persistence rate** was defined as the proportion of members with continuous medication use without a ≥ 60-day gap.
- **Discontinuation rate** was defined as the proportion of members who had a gap of ≥ 60 consecutive days without a prescription refill following the last fill.
- **Reinitiation rate** was defined as the proportion of members who discontinued therapy and subsequently had a prescription refill following a discontinuation gap of at least 60 days.

** Discontinuation, reinitiation, 12-month adherence, and 12-month persistence were assessed only for those who initiated GLP-1 RA AOMs between July 1, 2023 and December 31, 2024.*

Covariates

Member characteristics were assessed to better understand medication utilization patterns. Demographic variables included age, sex, race, and health plan, all measured at the index date. Comorbidities were identified during the 6-month baseline period and included type 2 diabetes mellitus, sleep apnea, metabolic dysfunction-associated steatotic liver disease, hypertension, hyperlipidemia, atrial fibrillation, heart failure, myocardial infarction, coronary heart disease, cerebrovascular disease, peripheral artery disease, atherosclerotic diseases, chronic kidney disease, acute kidney failure, end-stage renal disease, and depression. Hypertension, hyperlipidemia, and type 2 diabetes required both clinical diagnosis and evidence of medication use during baseline. Comedication with gastrointestinal medications (ondansetron, promethazine, and proton pump inhibitors [PPIs]) was also measured for those included in the 12-month follow-up period.

Statistical Analysis

Descriptive statistics were used to summarize demographic and clinical characteristics for the study population.

RESULTS

A total of 6,042 members initiated GLP-1 RA AOMs between July 2023 and June 2025. Among these, 4,231 satisfied the eligibility criterion of continuous enrollment with full Medicaid benefits during the baseline and follow-up periods. After restricting the sample to adults, the final analytic cohort consisted of 3,504 individuals. Table 1 summarizes the baseline demographic and clinical characteristics of the study population during the 3 initiation periods.

TABLE 1. Baseline Characteristics of Mississippi Medicaid Members Initiating GLP-1 RA AOMs July 2023 - June 2025

	Initiators July 2023 - December 2023	Initiators January 2024 - December 2024	Initiators January 2025 - June 2025
Baseline characteristics	**n = 437**	**n = 1,641**	**n = 1,426**
Gender			
Male	35 (8.01%)	142 (8.65%)	99 (6.94%)
Female	402 (91.99%)	1,499 (91.35%)	1,327 (93.06%)
Age			
18 - 39	261 (59.73%)	970 (59.11%)	903 (63.32%)
40 -64	176 (40.27%)	671 (40.89%)	523 (36.68%)
Race			
White	182 (41.65%)	511 (31.14%)	464 (32.54%)
Black	198 (45.31%)	816 (49.73%)	746 (52.31%)
Other	57 (13.04%)	314 (19.13%)	216 (15.15%)
Plan			
FFS	65 (14.87%)	118 (7.19%)	100 (7.01%)
MAG	156 (35.70%)	630 (38.39%)	529 (37.10%)
MOL	78 (17.85%)	331 (20.17%)	294 (20.62%)
UHC	138 (31.58%)	562 (34.25%)	503 (35.27%)
Clinical Characteristics			
Type 2 diabetes mellitus	46 (10.53%)	214 (13.04%)	168 (11.78%)
Sleep apnea	81 (18.54%)	279 (17.00%)	207 (14.52%)
MASLD	34 (7.78%)	104 (6.34%)	77 (5.40%)
Hypertension	198 (45.31%)	748 (45.58%)	603 (42.29%)
Hyperlipidemia	51 (11.67%)	265 (16.15%)	197 (13.81%)
Atrial fibrillation	15 (3.43%)	40 (2.44%)	27 (1.89%)
Heart failure	21 (4.81%)	120 (7.31%)	74 (5.19%)
Myocardial infarction	3 (0.69%)	7 (0.43%)	5 (0.35%)
Coronary heart disease	22 (5.03%)	81 (4.94%)	54 (3.79%)
Cerebrovascular disease	11 (2.52%)	35 (2.13%)	24 (1.68%)
Peripheral artery disease	9 (2.06%)	22 (1.34%)	22 (1.54%)
Atherosclerotic diseases	2 (0.46%)	4 (0.24%)	6 (0.42%)
Chronic Kidney Disease	15 (3.43%)	80 (4.88%)	68 (4.77%)
Acute Kidney Failure	6 (1.37%)	25 (1.52%)	16 (1.12%)
End-Stage Renal Disease	10 (2.29%)	66 (4.02%)	58 (4.07%)
Depression	156 (35.70%)	540 (32.91%)	415 (29.10%)
GI Medications*			
Ondansetron	199 (45.54%)	658 (40.10%)	NA
Promethazine	64 (14.65%)	202 (12.31%)	NA
PPI	145 (33.18%)	496 (30.23%)	NA
Composite (ondansetron, promethazine, PPI)	287 (65.68%)	963 (58.68%)	NA

Abbreviations: FFS - fee-for-service; MAG - Magnolia Health; MOL - Molina Healthcare; UHC - UnitedHealthcare; MASLD - Metabolic Dysfunction-Associated Steatotic Liver Disease; PPI - Proton Pump Inhibitors.
*Gastrointestinal (GI) medication use was measured during the 12-month follow-up period.

The demographic and clinical characteristics of initiators examined were generally consistent across each period. Females continued to outpace male initiators, climbing to 93% of initiators during the first half of 2025. Across all periods examined, most initiators were younger adults (18-39 years), Black, and enrolled in MCOs. Hypertension and depression were the 2 most common comorbid conditions present among initiators, and most initiators had claims for gastrointestinal medications during the 12-month follow-up period.

Adherent members were defined as the proportion of members with a PDC of at least 80% during each follow-up period examined (3, 6, and 12 months from initiation). As expected, the proportion of adherent members decreased with longer follow-up periods. Some interesting observations were found when examining each follow-up period. A greater proportion of members who initiated GLP-1 RA AOMs between January and June 2025 were adherent during both the 3- and 6-month follow-up periods (61.0% and 41.0%, respectively) as compared to those who initiated in earlier timeframes. This increased adherence can partially be attributed to the

resolution of drug shortages at the beginning of 2025 that had previously impacted the supply of GLP-1 RA AOMs.[2] While the proportion of members adherent improved, these figures are lower than recently published real-world data. In a study examining 6-month adherence to GLP-1 medications for members initiating treatment between July 2024 and December 2024 in a Medicaid population in Massachusetts, the proportion of members adherent at 6 months was reported at 60.1%.[3] Another study exploring trends in 1-year adherence to GLP-1 RAs among a sample of commercially insured individuals who initiated therapy in the first half year of 2024 found 55.5% were adherent.[4]

Exploring adherence by demographic characteristic subgroups, some trends were identified. A lower proportion of younger adults (18-39 years) and Black members were adherent compared to their counterparts. Adherence changes among FFS members were notable with adherence rates differing based on the initiation timeframe. While FFS had the lowest proportion of members adherent at the 3- and 6-month follow-up across all pharmacy plans among initiators between July 2023 and December 2024, FFS had the highest proportion of members adherent at 3- and 6-month follow-up among those who initiated therapy in 2025.

As shown in Table 3, persistence declined across each progressive timeframe examined (3-, 6-, and 12-months). Persistence was higher during each timeframe for members initiating therapy in 2024 and 2025 compared to those who initiated therapy in 2023. Interestingly, during the 3- and 6-month persistence timeframes, there were no major differences in persistence between members who initiated GLP-1 RA AOMs in 2025 compared to 2024. This suggests that the product shortage resolution did not play as significant a role in persistence as it did in adherence.

As with adherence, younger adults (18-39 years) and Black members generally had lower persistence compared to others. Like patterns displayed in adherence, members enrolled in FFS saw improvements in persistence at each timeframe for those initiating therapy in 2025, while persistence for those enrolled in the MCOs remained relatively flat for those initiating therapy in 2025 compared to 2024.

Similar to adherence, the persistence figures found among MS Medicaid members are lower than those reported in recent studies. Meyer et al[3] reported persistence at 6 months without a 56-day gap between claims at 60.8%, while the present study reports 6-month persistence without a 60-day gap at 51.6% for those initiating therapy in 2025. This figure dropped slightly from 52.7% for those initiating therapy in 2024. In their study examining 12-month persistence among commercially insured individuals, Marshall et al reported persistence without a 60-day gap at 60.9% for those initiating therapy in the first half of 2024.[4]

TABLE 2. Adherence Among GLP-1 RA AOM Initiators in Mississippi Medicaid July 2023 - June 2025

	Adherence+ at 3 months			Adherence+ at 6 months			Adherence+ at 12 months	
	Initiators July 2023 - December 2023	Initiators January 2024 - December 2024	Initiators January 2025 - June 2025	Initiators July 2023 - December 2023	Initiators January 2024 - December 2024	Initiators January 2025 - June 2025	Initiators July 2023 - December 2023	Initiators January 2024 - December 2024
	n=209, 47.83%	n= 917, 55.88%	n= 870, 61.01%	n= 149, 34.10%	n= 622, 37.90%	n= 584, 40.95%	n= 111, 25.40%	n= 414, 25.23%
Gender								
Male	15 (42.86%)	73 (51.41%)	59 (59.60%)	14 (40.00%)	56 (39.44%)	44 (44.44%)	9 (25.71%)	32 (22.54%)
Female	194 (48.26%)	844 (56.30%)	811 (61.12%)	135 (33.58%)	566 (37.76%)	540 (40.69%)	102 (25.37%)	382 (25.48%)
Age								
18 - 39	125 (47.89%)	533 (54.95%)	536 (59.36%)	85 (32.57%)	332 (34.23%)	350 (38.76%)	59 (22.61%)	212 (21.86%)
40 -64	84 (47.73%)	384 (57.23%)	334 (63.86%)	64 (36.36%)	290 (43.22%)	234 (44.74%)	52 (29.55%)	202 (30.10%)
Race								
White	94 (51.65%)	312 (61.06%)	317 (68.32%)	65 (35.71%)	199 (38.94%)	223 (48.06%)	53 (29.12%)	136 (26.61%)
Black	83 (41.92%)	425 (52.08%)	431 (57.77%)	58 (29.29%)	287 (35.17%)	278 (37.27%)	38 (19.19%)	186 (22.79%)
Other	32 (56.14%)	180 (57.32%)	122 (56.48%)	26 (45.61%)	136 (43.31%)	83 (38.43%)	20 (35.09%)	92 (29.30%)
Plan								
FFS	23 (35.38%)	56 (47.46%)	62 (62.00%)	16 (24.62%)	38 (32.20%)	50 (50.00%)	10 (15.38%)	31 (26.27%)
MAG	72 (46.15%)	336 (53.33%)	321 (60.68%)	51 (32.69%)	232 (36.83%)	210 (39.70%)	42 (26.92%)	146 (23.17%)
MOL	39 (50.00%)	199 (60.12%)	178 (60.54%)	30 (38.46%)	133 (40.18%)	119 (40.48%)	19 (24.36%)	85 (25.68%)
UHC	75 (54.35%)	326 (58.01%)	309 (61.43%)	52 (37.68%)	219 (38.97%)	205 (40.76%)	40 (28.99%)	152 (27.05%)
Clinical Characteristics								
Type 2 diabetes mellitus	26 (56.52%)	106 (49.53%)	103 (61.31%)	14 (30.43%)	78 (36.45%)	67 (39.88%)	9 (19.57%)	49 (22.90%)
Sleep apnea	34 (41.98%)	161 (57.71%)	125 (60.39%)	28 (34.57%)	126 (45.16%)	92 (44.44%)	24 (29.63%)	82 (29.39%)
MASLD	16 (47.06%)	55 (52.88%)	50 (64.94%)	14 (41.18%)	37 (35.58%)	33 (42.86%)	8 (23.53%)	23 (22.12%)
Hypertension	90 (45.45%)	423 (56.55%)	355 (58.87%)	70 (35.35%)	311 (41.58%)	261 (43.28%)	57 (28.79%)	211 (28.21%)
Hyperlipidemia	27 (52.94%)	139 (52.45%)	128 (64.97%)	22 (43.14%)	104 (39.25%)	81 (41.12%)	17 (33.33%)	66 (24.91%)
Cardiovascular conditions	15 (28.85%)	112 (53.59%)	84 (57.93%)	10 (19.23%)	81 (38.76%)	56 (38.62%)	9 (17.31%)	54 (25.84%)
Kidney-related conditions	6 (30.00%)	52 (57.78%)	43 (57.33%)	5 (25.00%)	40 (44.44%)	25 (33.33%)	6 (30.00%)	19 (21.11%)
Depression	68 (43.59%)	316 (58.52%)	253 (60.96%)	47 (30.13%)	205 (37.96%)	189 (45.54%)	35 (22.44%)	139 (25.74%)

Abbreviations: FFS - fee-for-service; MAG - Magnolia Health; MOL - Molina Healthcare; UHC - UnitedHealthcare; MASLD - Metabolic Dysfunction-Associated Steatotic Liver Disease

+ Adherence was defined as the proportion of members with a proportion of days covered (PDC) of at least 80% of days.

*Cardiovascular diseases include atrial fibrillation, heart failure, myocardial infarction, coronary heart disease, cerebrovascular disease, peripheral artery disease, and atherosclerotic diseases.

**Kidney-related conditions include chronic kidney disease, acute kidney failure, and end-stage renal disease.

TABLE 3. Persistence Among GLP-1 RA AOM Initiators in Mississippi Medicaid
July 2023 - June 2025

	Persistence at 3 months			Persistence at 6 months			Persistence at 12 months	
	Initiators July 2023 - December 2023	Initiators January 2024 - December 2024	Initiators January 2025 - June 2025	Initiators July 2023 - December 2023	Initiators January 2024 - December 2024	Initiators January 2025 - June 2025	Initiators July 2023 - December 2023	Initiators January 2024 - December 2024
	n= 290, 66.36%	n= 1,228, 74.83%	n= 1,057, 74.12%	n= 212, 48.51%	n= 865, 52.71%	n= 736, 51.61%	n= 149, 34.10%	n= 613, 37.36%
Gender								
Male	21 (60.00%)	112 (78.87%)	74 (74.75%)	18 (51.43%)	79 (55.63%)	51 (51.52%)	12 (34.29%)	51 (35.92%)
Female	269 (66.92%)	1,116 (74.45%)	983 (74.08%)	194 (48.26%)	786 (52.43%)	685 (51.62%)	137 (34.08%)	562 (37.49%)
Age								
18 - 39	171 (65.52%)	700 (72.16%)	668 (73.98%)	124 (47.51%)	475 (48.97%)	452 (50.06%)	84 (32.18%)	320 (32.99%)
40 -64	119 (67.61%)	528 (78.69%)	389 (74.38%)	88 (50.00%)	390 (58.12%)	284 (54.30%)	65 (36.93%)	293 (43.67%)
Race								
White	126 (69.23%)	398 (77.89%)	354 (76.29%)	89 (48.90%)	273 (53.42%)	262 (56.47%)	66 (36.26%)	195 (38.16%)
Black	117 (59.09%)	586 (71.81%)	547 (73.32%)	88 (44.44%)	416 (50.98%)	369 (49.46%)	57 (28.79%)	290 (35.54%)
Other	47 (82.46%)	244 (77.71%)	156 (72.22%)	35 (61.40%)	176 (56.05%)	105 (48.61%)	26 (45.61%)	128 (40.76%)
Plan								
FFS	37 (56.92%)	80 (67.80%)	75 (75.00%)	24 (36.92%)	59 (50.00%)	63 (63.00%)	17 (26.15%)	48 (40.68%)
MAG	97 (62.18%)	476 (75.56%)	394 (74.48%)	73 (46.79%)	337 (53.49%)	270 (51.04%)	53 (33.97%)	236 (37.46%)
MOL	50 (64.10%)	254 (76.74%)	225 (76.53%)	39 (50.00%)	171 (51.66%)	154 (52.38%)	24 (30.77%)	121 (36.56%)
UHC	106 (76.81%)	418 (74.38%)	363 (72.17%)	76 (55.07%)	298 (53.02%)	249 (49.50%)	55 (39.86%)	208 (37.01%)
Clinical Characteristics								
Type 2 diabetes mellitus	36 (78.26%)	157 (73.36%)	126 (75.00%)	23 (50.00%)	113 (52.80%)	90 (53.57%)	15 (32.61%)	69 (32.24%)
Sleep apnea	54 (66.67%)	222 (79.57%)	157 (75.85%)	44 (54.32%)	166 (59.50%)	115 (55.56%)	34 (41.98%)	122 (43.73%)
MASLD	19 (55.88%)	78 (75.00%)	60 (77.92%)	16 (47.06%)	56 (53.85%)	39 (50.65%)	11 (32.35%)	36 (34.62%)
Hypertension	133 (67.17%)	574 (76.74%)	434 (71.97%)	105 (53.03%)	410 (54.81%)	319 (52.90%)	73 (36.87%)	306 (40.91%)
Hyperlipidemia	41 (80.39%)	200 (75.47%)	148 (75.13%)	32 (62.75%)	143 (53.96%)	109 (55.33%)	25 (49.02%)	92 (34.72%)
Cardiovascular conditions	30 (57.69%)	156 (74.64%)	105 (72.41%)	19 (36.54%)	108 (51.67%)	69 (47.59%)	13 (25.00%)	76 (36.36%)
Kidney-related conditions	11 (55.00%)	71 (78.89%)	49 (65.33%)	10 (50.00%)	48 (53.33%)	30 (40.00%)	7 (35.00%)	33 (36.67%)
Depression	99 (63.46%)	416 (77.04%)	319 (76.87%)	71 (45.51%)	284 (52.59%)	238 (57.35%)	47 (30.13%)	203 (37.59%)

Abbreviations: FFS - fee-for-service; MAG - Magnolia Health; MOL - Molina Healthcare; UHC - UnitedHealthcare; MASLD - Metabolic Dysfunction-Associated Steatotic Liver Disease

*Cardiovascular diseases include atrial fibrillation, heart failure, myocardial infarction, coronary heart disease, cerebrovascular disease, peripheral artery disease, and atherosclerotic diseases.

**Kidney-related conditions include chronic kidney disease, acute kidney failure, and end-stage renal disease.

Table 4 summarizes the patterns of discontinuation and reinitiation among MS Medicaid members initiating GLP-1 RA AOMs between July 2023 and December 2024. Just over 50% of those initiating therapy discontinued treatment (60 or more days without a prescription claim) within 3 months of initiating therapy. Among those, only 14.6% reinitiated therapy after discontinuation. Almost 21% of members discontinued therapy between 3 to 6 months, with 45% of those reinitiating therapy. Approximately 29% of members discontinued therapy between 6 and 12 months, with 38.7% reinitiating therapy. The small proportion of members reinitiating therapy who discontinued treatment within 3 months could indicate these were members who discontinued therapy due to side effects. Conversely, the higher proportions of members who reinitiated therapy after discontinuing therapy more than 3 months after initiation could be a result of members whose treatment was interrupted due to supply issues.

TABLE 4. Discontinuation and Reinitiation Among GLP-1 RA AOM Initiators in Mississippi Medicaid, July 2023 - December 2024

	Less than 3 months		Between 3 and 6 months		Between 6 and 12 months	
	Discontinued (n=1,042, 50.22%)	Reinitiated (n= 152, 14.59%)	Discontinued (n=431, 20.77%)	Reinitiated (n= 194, 45.01%)	Discontinued (n=602, 29.01%)	Reinitiated (n= 233, 38.70%)
Gender						
Male	89 (50.28%)	17 (19.10%)	30 (16.95%)	14 (46.67%)	58 (32.77%)	18 (31.03%)
Female	953 (50.21%)	135 (14.17%)	401 (21.13%)	180 (44.89%)	544 (28.66%)	215 (39.52%)
Age						
18 - 39	580 (47.15%)	100 (17.24%)	285 (23.17%)	123 (43.16%)	365 (29.67%)	141 (38.63%)
40 -64	462 (54.67%)	52 (11.26%)	146 (17.28%)	71 (48.63%)	237 (28.05%)	92 (38.82%)
Race						
White	341 (49.21%)	38 (11.14%)	150 (21.65%)	61 (40.67%)	202 (29.15%)	60 (29.70%)
Black	500 (49.41%)	87 (17.40%)	223 (22.04%)	109 (48.88%)	289 (28.56%)	133 (46.02%)
Other	201 (54.32%)	27 (13.43%)	58 (15.68%)	24 (41.38%)	111 (30.00%)	40 (36.04%)
Plan						
FFS	100 (54.64%)	18 (18.00%)	45 (24.59%)	21 (46.67%)	38 (20.77%)	13 (34.21%)
MAG	395 (50.25%)	57 (14.43%)	168 (21.37%)	79 (47.02%)	223 (28.37%)	88 (39.46%)
MOL	192 (47.17%)	20 (10.42%)	88 (21.62%)	28 (31.82%)	127 (31.20%)	54 (42.52%)
UHC	355 (50.79%)	57 (16.06%)	130 (18.60%)	66 (50.77%)	214 (30.62%)	78 (36.45%)
Clinical Characteristics						
Type 2 diabetes mellitus	116 (44.96%)	17 (14.66%)	59 (22.87%)	21 (35.59%)	83 (32.17%)	33 (39.76%)
Sleep apnea	199 (55.28%)	27 (13.57%)	61 (16.94%)	26 (42.62%)	100 (27.78%)	31 (31.00%)
MASLD	62 (45.26%)	7 (11.29%)	36 (26.28%)	14 (38.89%)	39 (28.47%)	15 (38.46%)
Hypertension	497 (52.65%)	68 (13.68%)	181 (19.17%)	85 (46.96%)	266 (28.18%)	100 (37.59%)
Hyperlipidemia	151 (47.94%)	17 (11.26%)	66 (20.95%)	27 (40.91%)	98 (31.11%)	30 (30.61%)
Cardiovascular conditions*	124 (47.69%)	23 (18.55%)	59 (22.69%)	29 (49.15%)	77 (29.62%)	28 (36.36%)
Kidney-related conditions**	54 (49.09%)	6 (11.11%)	20 (18.18%)	10 (50.00%)	36 (32.73%)	12 (33.33%)
Depression	340 (48.85%)	46 (13.53%)	146 (20.98%)	65 (44.52%)	210 (30.17%)	93 (44.29%)

Abbreviations: FFS - fee-for-service; MAG - Magnolia Health; MOL - Molina Healthcare; UHC - UnitedHealthcare; MASLD - Metabolic Dysfunction-Associated Steatotic Liver Disease.

Discontinuation and reinitiation were assessed only for those who initiated GLP-1 RA AOMs between July 2023 and December 31, 2024.

*Cardiovascular diseases include atrial fibrillation, heart failure, myocardial infarction, coronary heart disease, cerebrovascular disease, peripheral artery disease, and atherosclerotic diseases.

**Kidney-related conditions include chronic kidney disease, acute kidney failure, and end-stage renal disease.

CONCLUSIONS

This real-world analysis of Mississippi Medicaid members initiating GLP-1 RA AOMs demonstrated that adherence and persistence improved substantially among individuals who began therapy in 2025 compared with those who initiated treatment in 2023. Despite these improvements, adherence and persistence rates among MS Medicaid members remain lower than those reported in recently published literature. Although national product shortages during 2023 and 2024 likely contributed to treatment interruptions, they do not fully explain the relatively low rates observed in this population. Additional factors may include medication-related adverse effects, barriers to consistent medication access, and gaps in care coordination or ongoing clinical management. Further research is needed to better understand these barriers and to identify strategies that may improve sustained use of GLP-1 RA AOMs among Medicaid members.

RECOMMENDATIONS

1. Mississippi Medicaid should explore opportunities to identify barriers to adherence and persistence with GLP-1 RA anti-obesity medications and develop strategies to support sustained use among Medicaid beneficiaries.

2. Mississippi Medicaid should consider evaluating the feasibility of incorporating adherence measures into reauthorization criteria for GLP-1 RA anti-obesity medications.

REFERENCES

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FDA DRUG SAFETY COMMUNICATIONS

December 2025 – February 2026

- **01-13-2026 FDA Requests Removal of Suicidal Behavior and Ideation Warning from Glucagon-Like Peptide-1 Receptor Agonist (GLP-1 RA) Medications**

What Is FDA Doing?

"FDA is requesting that drug application holders remove information regarding the risk of suicidal ideation and behavior (SI/B) from the labeling of glucagon-like peptide-1 receptor agonist (GLP-1 RA) medications that currently include such language. The affected products are Saxenda (liraglutide), Wegovy (semaglutide), and Zepbound (tirzepatide) (FDA.gov)."

"This action follows a comprehensive FDA review that found no increased risk of SI/B associated with the use of GLP-1 RA medications. Saxenda, Wegovy, and Zepbound are each approved for weight reduction in persons with obesity or overweight. At the time of the original FDA approvals, the labeling for each of these products included information in the *Warnings and Precautions* section about the potential risk of SI/B. Similar information about SI/B is also included in the labeling of other types of weight loss medicines and is based on reports of such events observed with a variety of older medicines used or studied for weight loss (FDA.gov)."

"Labeling for GLP-1 RA medications that are approved to improve glycemic (blood sugar) control or other complications in patients with type 2 diabetes mellitus does not currently include information on the risk of SI/B (FDA.gov)."

What Are GLP-1 RAs?

"GLP-1 RAs are a class of medicines that mimic the effects of a natural hormone called glucagon-like peptide-1 (GLP-1) that is released by the intestine. GLP-1 helps lower blood glucose (sugar) levels after eating and acts in parts of the brain that control appetite and food intake. FDA approved the first GLP-1 RA as adjunctive therapy to improve glycemic control in patients with type 2 diabetes mellitus in 2005. There are now several medications in this drug class on the market (FDA.gov)."

What Should Patients and Caregivers Do?

"Patients and caregivers should be aware that, after a comprehensive review, FDA found no increased risk of SI/B with the use of GLP-1 RA medications." Patients should continue taking medications as prescribed contact doctor for any potential concerns (FDA.gov)."

“Suicidal ideation occurs when a person is thinking, considering, or planning suicide. Suicidal behavior occurs when a person takes physical actions toward suicide, including suicide attempts or completed suicide (an act of self-harm that causes death). Tell your health care professional if you experience new or worsening depression, suicidal thoughts, or any unusual changes in mood or behavior. Call or text 988 or go to the website at https://988lifeline.org/External Link Disclaimer, which provides free support for people in distress 24 hours a day, 7 days a week (FDA.gov).”

What Should Health Care Professionals Do?

“Health care professionals should be aware that FDA found no increased risk of SI/B with the use of GLP-1 RA medications and is requesting the removal of this Warning and Precaution from the prescribing information for the GLP-1 RA medications (Saxenda, Wegovy, and Zepbound) that include such language. Health care professionals should be prepared to discuss with patients that the FDA has found no increased risk after conducting a comprehensive review of the available data. If individuals disclose that they are experiencing SI/B, refer them to mental health professionals for evaluation (FDA.gov).”

What Did FDA Find?

“The labeling of GLP-1 RA medications approved for weight reduction in persons with obesity or overweight contains information in the *Warnings and Precautions* section regarding a potential risk of SI/B. In July 2023, after receiving postmarketing reports of SI/B in patients taking GLP-1 RA medications, FDA initiated further investigation of the potential risk of SI/B for GLP-1 RA medications. FDA performed a preliminary review of clinical trial and postmarketing data, including observational studies and case reports, and publicly reported those findings in its January 2024 Drug Safety Communication (FDA.gov).”

What Did FDA Find?

“The initial review of GLP-1 RA clinical trial data did not find an association between the use of GLP-1 RAs and the occurrence of SI/B. However, because of the small number of cases of SI/B observed in individual trials, there was considerable uncertainty in the risk estimate. To address this concern, FDA performed a comprehensive meta-analysis of clinical trials across GLP-1 RA drug development programs to improve the precision of the risk estimate.The meta-analysis assessed the risk of SI/B comparing GLP-1 RA medications to placebo. There were 91 placebo-controlled GLP-1 RA medication trials in the meta-analysis that included 107,910 patients (60,338

treated with a GLP-1 RA and 47,572 treated with placebo). The results did not show an increased risk for SI/B or for other relevant psychiatric adverse events such as anxiety, depression, irritability, or psychosis. In addition, FDA conducted a retrospective cohort study using administrative healthcare claims data from the FDA Sentinel System to compare the risk of intentional self-harm between new users of GLP-1 RAs and sodium-glucose cotransporter 2 inhibitors (SGLT2i) in patients with type 2 diabetes mellitus. The study population included 2,243,138 users (1,161,983 initiated on a GLP-1 RA and 1,081,155 initiated on a SGLT2i) from 10 data partners during the period between October 1, 2015, and September 20, 2023. After controlling for baseline confounders in the study, FDA did not find an increased risk of intentional self-harm in GLP-1 RA users compared to SGLT2i users. Similarly, the FDA did not find an increased risk in the subgroup of patients with both type 2 diabetes mellitus and obesity (FDA.gov)."

"FDA also reviewed published observational and pooled studies evaluating the relationship between GLP-1 RAs and SI/B, and related outcomes. Our review concluded that the totality of these studies does not support a causal relationship between the use of GLP-1 RAs and the occurrence of SI/B (FDA.gov)."

"Therefore, consistent with these findings, FDA is requesting that application holders remove information regarding the risk of SI/B from the labeling of GLP-1 RA medications that currently include such language (FDA.gov)."

How Do I Report Side Effects from GLP-1 RAs?

"To help FDA track safety issues with medicines, we urge patients and health care professionals to report side effects involving GLP-1 RAs or other medicines to the FDA MedWatch program using the information in the "Contact FDA" box at the bottom of this page (FDA.gov)."

How Can I Get New Safety Information on Medicines I'm Prescribing or Taking?

"To help FDA track safety issues with medicines, we urge patients and health care professionals to report side effects involving GLP-1 RAs or other medicines to the FDA MedWatch program using the information in the "Contact FDA" box at the bottom of this page (FDA.gov)."

Works Cited

1. Center for Drug Evaluation and Research, F. (2026, January 13). *FDA requests removal of suicidal behavior and ideation warning from GL*. U.S. Food and Drug Administration. https://www.fda.gov/drugs/drug-safety-and-availability/fda-requests-removal-suicidal-behavior-and-ideation-warning-glucagon-peptide-1-receptor-agonist-glp

Division of Medicaid
Drug Utilization Review Board
By-Laws

Article I. Purpose

The Drug Utilization Review Board (DUR) is a requirement of the Social Security Act, Section 1927. The purpose of the DUR Board is to provide clinical guidance to the Division of Medicaid (DOM) regarding the utilization of pharmaceutical products within the Mississippi Medicaid program. The DUR Board makes recommendations to DOM to promote patient safety and cost effective care in the Mississippi Medicaid program. The DUR Board shall advise DOM with respect to the content of medical criteria and standards for utilization management strategies including prospective drug prior authorization (PA), concurrent patient management, retrospective drug utilization review, and educational intervention programs. DOM retains the authority to accept or reject the recommendations by the DUR Board.

Article II. Membership

Section 1 – Board Composition

A. The DUR Board will consist of not less than twelve (12) voting members.
B. The DUR Board voting members will be comprised of at least one-third (1/3), but no more than fifty-one percent (51%), licensed and actively practicing physicians and at least one-third (1/3) licensed and actively practicing pharmacists. Voting members may consist of health care professionals with knowledge/expertise in one or more of the following:
   1) Prescribing of drugs,
   2) Dispensing and monitoring of drugs,
   3) Drug use review, evaluation, and intervention,
   4) Medical quality assurance.
C. Non-voting board members consist of the Division of Medicaid (DOM) Executive Director, Office of Pharmacy pharmacists, DUR Coordinator, the DUR contractor and Medical Director.

Section 2 – Appointment selection methodology

A. DOM's Office of Pharmacy in consultation with officially recognized state professional healthcare associations recommends potential, qualified new candidates for appointment or reappointment of existing board members to DOM's Executive Director.
B. Nominations are considered internally and appointments are given final approval by the DOM Executive Director.
C. Board members are appointed by the Governor of the State of Mississippi, or Governor's designee, pursuant to state law.

Section 3 - Term of Office

A. All members are appointed for three year terms following a staggered appointment fulfillment as follows: one-third of DUR Board members shall be appointed each term. All subsequent appointments shall be for terms of three years from the expiration date of the previous term.
B. Members may serve up to three consecutive three-year terms (for a total of nine consecutive years).
C. Members may serve for either an extended term or a fourth consecutive term at the discretion of the Executive Director and by recommendation of both the DUR Coordinator and Division of Medicaid Office of Pharmacy in the event that no qualified, willing candidate is found in sufficient time. Members, including those filling vacated positions, may be re-appointed by the Executive Director for a subsequent term.
D. In the event of an unexpected or expected vacancy, the DUR Coordinator and Office of Pharmacy may recommend a qualified replacement candidate to DOM's Executive Director for emergency approval.
E. The Executive Director shall fill any vacancy before the end of the term, and the person appointed to fill the vacancy shall serve for the remainder of the unexpired term. Members, including those filling vacated positions, may be re-appointed by the Executive Director for a subsequent term.

Section 4 - Attendance

A. Members are required to attend at least fifty percent of the meetings per year. Failure to attend meetings without an explanation of extenuating circumstances will result in the termination of the member's appointment.
B. Members are asked to give advance notice regarding any planned absences so that a quorum may be determined prior to meetings.

Section 5 - Resignation

A member of the DUR Board may resign by giving a 30 day written advance notice to the DUR Board Chair and DUR Coordinator.

Section 6 - Removal

A member of the DUR Board may be removed by either the DUR Board Chair or majority vote of the DUR Board for good cause. Good cause may be defined as one or more of the following conditions:

A. Lack of attendance –failure to attend at least 50% of the scheduled DUR meetings shall constitute a resignation by said DUR Board member,
B. Identified misconduct or wrongdoing during any DUR Board term, or

C. Not disclosing a conflict of interest either upon initial disclosure or throughout the rest of the term.

Section 7 - Board Officers

At the first meeting of the state fiscal year, which constitutes July 1 through June 30, board members shall select two members to serve as Chair and Chair-Elect of the board, respectively. The Chair and Chair-Elect shall both serve one year terms. At the end of the serving year, the Chair-Elect assumes the role of Chair, and a new Chair-Elect will be chosen.

If the persons serving as Chair and Chair-Elect have either previously served as Chair or Chair-Elect, that person may be reelected to either posting.

The Chair-Elect will serve as Chair in absentia of the Chair or by the Chair's request.

Section 8 – Reimbursement

The Division of Medicaid will reimburse DUR Board members for travel related expenses.

Article III. Meetings

Section 1 – Frequency

The DUR Board shall meet at least quarterly, and may meet at other times as necessary for the purpose of conducting business that may be required. The DUR Board Chair, a majority of the members of the board, or the Division of Medicaid Office of Pharmacy and DUR Coordinator, shall maintain the authority of calling DUR meetings.

Section 2 – Regular Meetings

The DUR Board will hold regular quarterly meetings in the city of Jackson, Mississippi. Meetings will occur at the predesignated time and place. Dates for the upcoming year's quarterly meetings will be posted before the first quarterly meeting of the upcoming year.

Section 3 – Special Meetings

The DUR Board may meet at other times other than regular quarterly meetings as deemed necessary and appropriate. The DUR Coordinator and Office of Pharmacy must notify DUR Board members of any special meeting at least two weeks, i.e., ten (10) days, prior to the requested meeting date. Special meetings may be requested by the following officials:

A. Division of Medicaid Executive Director,
B. DUR Coordinator and Office of Pharmacy,
C. DUR Board Chair, or
D. Majority of DUR Board members via communication to DUR Coordinator and/or DUR Board Chair.

Section 4 – Meeting Notice

DUR Board members will be notified of the location for the meeting a minimum of ten (10) days in advance. Notification may include one or a combination of the following methods: e-mail, fax, or other written communication. DUR Board members are required to keep on file with
DOM Office of Pharmacy his or her address, primary phone number, alternate phone number (i.e., cell), fax number, and email address to which notices and DUR related communications may be submitted.

Meetings may be cancelled due to lack of quorum, severe inclement weather, or other reasons as determined by the DUR Coordinator and Office of Pharmacy. In the event of a cancellation, the DUR Coordinator and DOM Pharmacy staff will communicate with DUR Board members regarding the meeting cancellation as soon as circumstances permit. Notifications shall also be posted with DFA and on DOM's website to ensure that the public is notified of any meeting cancellation.

DUR Board Meetings shall be open to the public and conducted in accordance with state law, specifically the Open Meetings Act. Notice of any meetings held shall be provided at least five (5) days in advance of the date scheduled for the meeting. The notice shall include the date, time, place and purpose for the meeting and shall identify the location of the meeting to the general public.

Section 5 – Meeting Sign-In

All meeting attendees will be required to sign-in at the meeting entrance for DUR meetings. Sign-in sheets will be logged, scanned and transferred to electronic medium for official records. All attendees shall include participant's name and entity represented (as applicable).

Section 6 – Quorum

A simple majority of voting board members shall constitute a quorum and must be present for the transaction of any business of the board. For a fully-appointed 12-person DUR Board as required by state law, seven voting board members constitutes a quorum. If a quorum is not present, the Chair, Chair-Elect or DUR Coordinator maintains the responsibility to conclude meeting proceedings. Meeting minutes shall reflect that a quorum was not present.

Section 7 – Voting

The voting process shall be conducted by the Chair or the Chair-Elect in absentia of the Chair.

All board recommendations shall begin with a motion by a voting board member. The motion may then be seconded by a voting board member. If a recommendation does not receive a second motion, the motion shall not pass. If a recommendation receives a second motion, then the board shall vote on the motion. A motion shall be considered as passed if the motion carries a majority of votes if a quorum of the board is present.

In the event that a motion receives a tie vote in the presence of a quorum, the motion shall not pass. The motion can be brought up for further discussion after which a subsequent motion may be made to vote on the issue again during the same meeting, or a motion can be made to table the issue and discussion until the next quarterly DUR Board meeting.

A vote abstention occurs when a voting member is present for the meeting and the action but has chosen not to vote on the current motion. An abstention is a vote with the majority on the measure. A recusal, on the other hand, is necessitated when a voting member has a conflict of interest or potential pecuniary benefit resulting from a particular measure. In order to properly and completely recuse oneself from a matter, the DUR Board member must leave the room or area where discussions, considerations, or other actions take place

before the matter comes up for discussion. The member must remain absent from the meeting until the vote is concluded. The minutes will state the recusing member left the room before the matter came before the DUR Board and did not return until after the vote.

Section 8 – Minutes

A public body speaks only through its minutes. State law, specifically the Open Meetings Act, requires minutes be kept of all meetings of a public body, whether in open or executive session, showing the following:

A. Members present or absent,
B. Date, time and place of meeting,
C. Accurate recording of any final actions taken,
D. Record, by individual member, of how s/he voted on any final action, and
E. Any other information that the public body requests is reflected in the minutes.

The minutes shall be finalized no later than thirty (30) days after the adjournment of the DUR Board meeting and shall be made available for public inspection. DOM Office of Pharmacy posts all DUR Board Minutes on the DUR webpage.

Section 9 – Speakers & Special Topics

DUR Board members may request various healthcare, industry, or specialized professionals to present at DUR meetings regarding a posted topic on an upcoming DUR agenda.

A. The DUR Board may allow up to 20 minutes for topic presentation by an invited speaker.
B. DUR Board Members may ask a member of the audience to provide information on a topic being discussed by the Board. Invited participants may be asked to disclose any potential conflicts of interests if applicable. (See Article IV, Section 1).
C. Members of the audience may not speak unless so designated at the appropriate time by a DUR Board member.
D. DUR Board Members, both voting and non-voting, maintain speaking privileges at DUR meetings.
E. Contracted employees of DOM and employees of other DOM vendors are considered members of the audience.

Section 10 – Executive Session

During special circumstances, the DUR Board may go into executive session at the conclusion of normal meeting proceedings; however, all DUR Board meetings must commence as an open meeting. In order for executive session to be called, the following procedure must be followed in accordance with the Open Meetings Act:

A. A member may <u>move to close</u> the meeting to determine whether board needs to go into executive session; vote in open meeting with vote recorded in minutes, majority rules.
B. Closed meeting: vote taken on whether to <u>declare</u> executive session, requires 3/5 of all members present.
C. Board comes back into open session and states statutory reason for executive session. The reason for the executive session shall be recorded in the meeting minutes.
D. Board members then will go into executive session where action may be taken on stated subject matter only.

E. Minutes must be kept in accordance with the Open Meetings Act.

Section 11 – Conduct of Participants

Pursuant to state law, specifically the Open Meetings Act, the DUR Board may make and enforce reasonable rules and regulations for the conduct of persons attending the DUR meetings. The following is a non-exhaustive list of rules for DUR Board meetings:

A. Attendees should please remain silent and allow for the efficient transaction of business.
B. Cell phones should be placed on silent or vibrate.
C. Laptop computers are discouraged from being utilized during meetings as frequent typing may distract board members.
D. Food and drink are not allowed in the meeting room.
E. Security is provided by the state. Guests not following proper decorum may be asked to leave by security.

Article IV. Public Participation

Section 1 - Disclosure of Persons Appearing Before DUR Board

The DUR Board may ask individuals appearing before the board to disclose either in writing or verbally their relationship, as applicable, including but not limited to pharmaceutical companies or special interest groups. Any such disclosures should be recorded as a matter of public record in the documented meeting minutes.

Article V. Conflicts of Interest

DUR Board members are expected to maintain the highest professional, ethical standards. A conflict of interest may exist when a DUR Board member maintains a financial/pecuniary, personal, or professional interest that may compete or interfere with the DUR Board member's ability to act in a fair, impartial manner while acting in the best interests of the Division of Medicaid and the beneficiaries that it serves.

As such, DUR Board members are required to complete and submit annually a Conflict of Interest disclosure statement with the DOM Office of Pharmacy and DUR Coordinator. Statements shall be maintained by the Office of Pharmacy. Members have an ongoing responsibility to update and revise said statements, disclosing any new conflicts of interest to the DUR Coordinator and DOM Office of Pharmacy.

It is the sole responsibility and requirement of each board member to review the agenda of each forthcoming board meeting to determine any if any potential conflicts of interest exist. If so, an aforementioned Disclosure statement must be updated indicating the conflict of interest. The board member should notify the Chair or Chair-Elect of the conflict of interest prior to the meeting.

A DUR Board member shall recuse himself/herself from any vote, action, or discussion pertaining to any product or product class if there is documentation stating an actual or perceived conflict of interest. Please refer to the procedure outlined in Article III, Section 7.

Article VI. Confidentiality

DUR Board members are required to safeguard all confidential and proprietary information, including but not limited to pricing information, which is disclosed by the Mississippi Division of Medicaid for purposes of conducting DUR Board activities. Any provider or patient specific information discussed by the DUR Board shall also be kept strictly confidential in accordance with state and federal law.

Article VII. Amendments

Proposed Amendments of By-Laws

A. Proposed amendments must be submitted to the DUR Coordinator at least thirty (30) days prior to the next scheduled DUR meeting and the proposed amendments will be disseminated to the DUR Board en masse for consideration at said DUR Board meeting.
B. Proposed amendments will be distributed to board members no less than five (5) business days prior to next DUR Board meeting.
C. Proposed amendments will be initiated by the Chair, or the Chair-Elect in absentia of the Chair, prior to Next Meeting Information announcements.
D. Proposed amendments will be voted upon at the next scheduled DUR Board meeting. If majority of DUR Board votes to ratify amendment, the amendment will take effect immediately at the conclusion of the meeting.

MS-DUR BOARD
COMMON ABBREVIATIONS

AWP	Any Willing Provider, Average Wholesale Price
BENE	Beneficiary
CAH	Critical Access Hospital
CCO	Coordinated Care Organization
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Program
CMS	Center for Medicare and Medicaid Services
COB	Coordination of Benefits
CPC	Complex Pharmaceutical Care
DME	Durable Medical Equipment
DOC	Department of Corrections
DOM	Division of Medicaid
DUR	Drug Utilization Review
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FA	Fiscal Agent
FFS	Fee For Service
FPW	Family Planning Waiver
FQHC	Federally Qualified Health Clinic
FY	Fiscal Year
HB	House Bill
HCPCS/ HEIDIS	Health Plan Employer Data and Information Set
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability
IDD	Intellectual and Developmental Disabilities
LTC	Long Term Care
MAG	Magnolia Health
MEDD	Morphine Equivalent Daily Dose
MOL	Molina Healthcare
MPR	Medication Possession Ratio
MSCAN	Mississippi Coordinated Access Network
MSDH	Mississippi State Department of Health
NADAC	National Average Drug Acquisition Cost
NDC	National Drug Code
P&T	Pharmacy and Therapeutics
PA	Prior Authorization
PBM	Pharmacy Benefit Manager
PDC	Proportion of Days Covered
PDL	Preferred Drug List
PI	Program Integrity
PIP	Performance Improvement Program
POS	Point of Sale, Place of Service, Point of Service
Pro-DUR	Prospective Drug Use Review
OTC	Over the Counter
QI	Quality Indicator
QIO	Quality Improvement Organization
QM	Quality Management
RA	Remittance Advise
REOMB	Recipient's Explanation of Medicaid Benefits
Retro-DUR	Retrospective Drug Utilization Review
RFI	Request for Information
RFP	Request for Proposal
RHC	Rural Health Clinic
SB	Senate Bill
SCHIP	State Child Health Insurance Program
SMART PA	Conduent's Pharmacy Application (SmartPA) is a proprietary electronic prior authorization system used for Medicaid fee for service claims
SPA	State Plan Amendment
UHC	United Healthcare
UM/QIO	Utilization Management and Quality Improvement Organization
UPDL	Universal Preferred Drug List
UR	Utilization Review
VFC	Vaccines for Children
WAC	Wholesale Acquisition Cost
WIC	Women, Infants, Children
340B	Federal Drug Discount Program