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

MISSISSIPPI DIVISION OF
MEDICAID

November 20, 2014 at 2:00pm

Woolfolk Building, Room 138
(not usual meeting room)
Jackson, MS

Prepared by:

The University of Mississippi School of Pharmacy

Evidence-Based DUR Initiative, MS-DUR

MS | DUR

Drug Utilization Review Board

Allison Bell, Pharm.D.
University of MS School of Pharmacy
2500 North State St.
Jackson, MS 39216
Term Expires: June 30, 2015

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

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

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

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

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

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

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

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

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

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

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

2015 DUR Board Meeting Dates

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

As with any analysis, great efforts are made to ensure that the information reported in this document is accurate. The most recent administrative claims data available are being used at the time the reports are generated, which includes the most recent adjudication history. As a result, values may vary between reporting periods and between DUR Board meetings, reflecting updated reversals and claims adjustments.

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

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

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

MISSISSIPPI DIVISION OF MEDICAID

OFFICE OF THE GOVERNOR

DRUG UTILIZATION REVIEW BOARD

AGENDA

November 20, 2014

Welcome — Dennis Smith, R.Ph. (Chair)

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

- Approval of August 2014 Meeting Minutes — *page 6*

Resource Utilization Review — Ben Banahan, Ph.D.

- Enrollment Summary — *page 12*
- Pharmacy Utilization Summary — *page 12*
- Top 25 Drugs by Number of Claims — *page 13*
- Top 25 Drugs by Amount Paid — *page 18*
- Top 10 Drug Movement by Amount Paid — *page 23*
- Top 10 Drug Movement by Number of Claims — *page 24*

Pharmacy Program Update — Judy Clark, R.Ph. Shannon Hardwick, R.Ph.

New Business

Special Analysis Projects (short titles)

- Metabolic Screening for Children on Antipsychotics (Banahan) — *page 26*
- Use of Opioids at Higher Doses in Persons Without Cancer – Morphine Equivalent Dose Limits (Banahan) — *page 33*
- Oral Birth Control Pills Restriction to Birth Control (Banahan & Hardwick) — *page 39*
- Weight Loss Clinical Edit for Naltrexone and Buproprion Combination (Banahan & Hardwick) — *page 42*

Exceptions Monitoring

- Exceptions Monitoring Criteria Recommendations — *page 45*

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

DUR Board Meeting Minutes

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

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

Also Present:

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

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

Xerox Staff:
Leslie Leon, Pharm.D.

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

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

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

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

Pharmacy Program Update:

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

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

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

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

Election of Officers:

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

Resource Utilization Review:

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

New Business:

Buprenorphine-Naloxone Utilization in FFS and MSCAN

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

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

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

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

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

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

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

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

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

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

Other Business

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

Next Meeting Information:

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

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

APPENDIX

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

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

Age ≤ 1 year at start of RSV season and one of the following:

- Prematurity of ≤ 28 weeks 6 days gestation
- Documentation of **chronic lung disease** (CLD) of prematurity defined as gestational age of 29 weeks 0 days – 31 weeks 6 days **AND** requirement for oxygen >21% for at least the first 28 days after birth.
- Documentation of **hemodynamically significant CHD AND** one of the following:
  (1) **acyanotic heart disease** receiving medication for congestive heart failure **AND** will require cardiac surgery.
  (2) **moderate to severe pulmonary** hypertension.
  (3) Documentation of **cyanotic heart disease** through consultation with pediatric cardiologist.
- Documentation of **congenital abnormalities of the airway OR neuromuscular disease** that impairs the ability to clear secretions from the upper airway because of ineffective cough.
- Documentation of **cystic fibrosis AND** clinical evidence of CLD **OR** nutritional compromise.
- Documentation of **profound immunocompromise** during the RSV season.

Age 12 – 24 months at start of RSV season and one of the following:

- Documentation of **chronic lung disease** (CLD) of prematurity defined as gestational age of 29 weeks 0 days – 31 weeks 6 days **AND** requirement for oxygen >21% for at least the first 28 days after birth **AND** required continued medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the RSV season.
- Documentation of **cystic fibrosis AND** one of the following:
  (1) manifestations of **severe lung disease** (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest compute tomography that persists when stable).
  (2) weight for length < 10^{th} percentile.
- Documentation of **profound immunocompromise** during the RSV season.

Coverage limitations:

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

NOTES:

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

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

Resource Utilizaton Review

ENROLLMENT STATISTICS FOR LAST 12 MONTHS April 1, 2014 through September 30 - 2014							
			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total enrollment			696,681	700,700	704,367	707,777	708,905	706,314
Dual-eligibles			153,426	153,279	153,313	153,159	153,014	152,830
Pharmacy benefits			595,666	599,884	603,558	606,889	608,115	604,931
	LTC		17,699	17,689	17,611	17,555	17,306	17,000
	PLAN %	FFS	75.5%	75.3%	74.9%	74.5%	74.1%	73.7%
		MSCAN-Magnolia	11.1%	11.2%	11.4%	11.6%	11.7%	11.9%
		MSCAN-Magnolia	13.5%	13.5%	13.7%	13.9%	14.2%	14.4%

PHARMACY UTILIZATION STATISTICS FOR LAST 12 MONTHS April 1, 2014 through September 30, 2014							
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
# Rx Fills	FFS	1,362,027	1,357,131	1,338,959	1,322,292	1,308,357	1,300,162
	MSCAN-UHC	546,462	554,280	561,893	564,602	562,029	552,191
	MSCAN-Mag	632,130	642,419	658,884	667,072	669,489	663,878
# Rx Fills / Bene	FFS	3.0	3.0	3.0	2.9	2.9	2.9
	MSCAN-UHC	8.3	8.3	8.2	8.0	7.9	7.7
	MSCAN-Mag	7.9	7.9	8.0	7.9	7.8	7.6
$ Paid Rx	FFS	$19,513,925	$21,273,281	$20,640,471	$20,657,164	$22,168,040	$23,087,256
	MSCAN-UHC	$10,396,288	$7,893,548	$7,299,645	$6,471,540	$7,934,216	
	MSCAN-Mag	$4,680,224	$5,230,014	$10,180,563	$7,568,385		
$ /Rx Fill	FFS	$14.33	$15.68	$15.42	$15.62	$16.94	$17.76
	MSCAN-UHC	$19.02	$14.24	$12.99	$11.46	$14.12	
	MSCAN-Mag			$15.45	$11.35		
$ /Bene	FFS	$43.41	$47.08	$45.65	$45.70	$49.20	$51.76
	MSCAN-UHC	$157.38	$117.70	$106.56	$92.09	$111.13	
	MSCAN-Mag	$58.42	$64.63	$122.94	$89.46		

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

Detail Resource Utilization Report - Top 25 Drugs by Number of Claims Last Month

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
Cetirizine	$203,648	$228,993	$238,468	11,003	13,783	12,973	10,820	13,622	12,872
-------Cetirizine Hydrochloride	$201,312	$225,584	$236,373	10,770	13,481	12,705	10,593	13,329	12,605
-------All Day Allergy	$1,750	$2,651	$1,548	190	251	224	188	247	223
-------All Day Allergy Children's	$586	$758	$548	43	51	44	42	51	44
Amoxicillin	$75,213	$116,742	$107,509	7,163	10,146	9,791	7,036	9,998	9,641
-------Amoxicillin	$75,213	$116,742	$107,509	7,163	10,146	9,791	7,036	9,998	9,641
Albuterol	$359,918	$564,692	$448,022	6,867	11,385	9,389	5,925	9,891	8,261
-------Albuterol Sulfate	$88,433	$146,500	$144,742	2,808	4,915	4,519	2,724	4,790	4,405
-------Proventil Hfa	$227,876	$253,434	$172,822	3,253	3,543	2,483	3,190	3,473	2,452
-------Ventolin Hfa	$29,466	$99,440	$81,052	559	1,821	1,534	544	1,798	1,524
-------Proair Hfa	$13,815	$64,844	$49,107	235	1,091	842	232	1,079	835
Azithromycin	$131,235	$239,004	$250,994	4,024	8,236	7,639	3,965	8,106	7,530
-------Azithromycin	$108,210	$194,204	$212,131	3,025	5,988	5,962	2,985	5,896	5,881
-------Azithromycin 5 Day Dose Pack	$22,266	$42,462	$36,991	965	2,144	1,601	953	2,129	1,588
-------Azithromycin 3 Day Dose Pack	$758	$2,338	$1,871	34	104	76	33	103	75
Montelukast	$1,322,187	$1,590,710	$1,470,795	7,073	8,410	7,467	6,938	8,319	7,407
-------Singulair	$1,322,187	$1,590,710	$1,470,795	7,073	8,410	7,467	6,938	8,319	7,407
Brompheniramine/ Dextromethorph/Phenylephrine	$20,926	$71,547	$54,789	2,496	6,678	6,635	2,461	6,589	6,532
-------Rynex Dm	$17,963	$62,351	$47,615	2,146	5,790	5,758	2,120	5,720	5,678
-------Endacof-Dm	$2,302	$6,838	$5,386	260	615	608	254	602	596
-------Dimaphen Dm	$355	$1,657	$1,078	53	185	176	53	184	173

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

Detail Resource Utilization Report - Top 25 Drugs by Number of Claims Last Month

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
Lisdexamfetamine	$919,552	$1,123,952	$1,111,275	4,409	5,446	5,318	4,211	5,269	5,185
-------Vyvanse	$919,552	$1,123,952	$1,111,275	4,409	5,446	5,318	4,211	5,269	5,185
Prednisolone	$53,687	$92,728	$80,839	3,245	5,767	5,032	3,165	5,619	4,901
-------Prednisolone Sodium Phosphate	$25,254	$47,420	$44,339	1,595	2,960	3,034	1,565	2,899	2,973
-------Prednisolone	$22,788	$37,022	$26,875	1,576	2,718	1,914	1,557	2,684	1,887
-------Orapred Odt	$3,625	$6,130	$6,553	34	53	49	34	53	45
-------Veripred 20	$1,924	$2,106	$2,779	39	35	34	38	35	34
Acetaminophen-Hydrocodone	$112,408	$90,549	$86,608	5,478	5,004	4,498	4,938	4,528	4,138
-------Acetaminophen-Hydrocodone Bitartrate	$112,408	$90,347	$86,598	5,478	5,002	4,497	4,938	4,527	4,138
Amoxicillin-Clavulanate	$189,287	$226,387	$271,411	3,041	4,472	4,338	2,999	4,411	4,273
-------Amoxicillin-Clavulanate	$183,741	$218,295	$266,356	3,035	4,462	4,332	2,994	4,401	4,267
-------Augmentin	$5,547	$8,092	$4,061	6	10	5	6	10	5
-------Augmentin Xr	$0	$0	$995	0	0	1	0	0	1
Methylphenidate	$649,709	$736,745	$709,444	3,924	4,445	4,250	3,575	4,093	3,955
-------Methylphenidate Hydrochloride Er	$457,125	$480,880	$437,126	2,744	2,892	2,638	2,592	2,753	2,549
-------Methylphenidate Hydrochloride	$7,003	$12,843	$8,771	402	523	516	385	500	495
-------Quillivant Xr	$78,869	$108,485	$117,610	327	460	482	316	451	474
-------Metadate Cd	$57,084	$75,746	$84,869	241	324	363	226	311	350
-------Daytrana	$42,710	$46,683	$50,121	179	195	207	171	188	205
-------Methylin	$5,456	$9,095	$5,687	15	28	15	15	27	15
-------Concerta	$487	$1,305	$3,378	2	6	11	2	5	11

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

Detail Resource Utilization Report - Top 25 Drugs by Number of Claims Last Month

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
-------Methylphenidate Hydrochloride Sr	$513	$435	$619	11	9	11	10	9	11
-------Ritalin La	$399	$1,165	$1,199	2	6	6	2	5	4
Ibuprofen	$34,998	$48,837	$42,045	3,360	4,104	4,174	3,297	4,038	4,114
-------Ibuprofen	$32,582	$45,172	$39,106	3,032	3,708	3,774	2,976	3,649	3,728
-------Ibuprofen Children's	$1,504	$2,070	$1,805	175	189	209	169	186	205
-------Ibu	$794	$1,311	$952	140	182	172	139	181	171
Mupirocin Topical	$145,156	$126,072	$151,784	4,339	4,304	4,172	4,243	4,216	4,069
-------Mupirocin	$121,599	$103,704	$135,536	4,147	4,113	4,037	4,060	4,033	3,941
-------Bactroban	$23,557	$22,368	$16,249	192	191	135	189	191	134
Amphetamine-Dextroamphetamine	$535,291	$607,408	$582,956	3,386	3,901	3,654	2,840	3,297	3,207
-------Adderall Xr	$443,288	$515,084	$488,803	1,860	2,230	2,076	1,736	2,086	1,990
-------Amphetamine-Dextroamphetamine	$91,854	$92,324	$93,517	1,525	1,671	1,575	1,378	1,534	1,485
-------Adderall	$149	$0	$637	1	0	3	1	0	3
Sulfamethoxazole-Trimethoprim	$40,671	$55,459	$78,125	3,247	3,091	3,066	3,184	3,037	3,024
-------Sulfamethoxazole-Trimethoprim Ds	$15,032	$15,951	$15,290	1,551	1,627	1,538	1,520	1,601	1,524
-------Sulfamethoxazole-Trimethoprim	$25,621	$39,469	$62,820	1,694	1,460	1,526	1,670	1,442	1,510
Guanfacine	$543,727	$552,021	$520,268	3,085	3,266	3,066	2,912	3,106	2,965
-------Intuniv	$523,737	$530,439	$499,049	1,732	1,798	1,651	1,640	1,714	1,615
-------Guanfacine Hydrochloride	$19,991	$21,582	$21,219	1,353	1,468	1,415	1,282	1,407	1,362
Mometasone Nasal	$440,818	$559,288	$527,384	2,633	3,155	2,871	2,615	3,143	2,870

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

Detail Resource Utilization Report - Top 25 Drugs by Number of Claims Last Month

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
-------Nasonex	$440,818	$559,288	$527,384	2,633	3,155	2,871	2,615	3,143	2,870
Clonidine	$147,109	$141,627	$124,552	3,027	3,089	2,799	2,803	2,913	2,723
-------Clonidine Hydrochloride	$23,699	$26,269	$21,993	2,604	2,695	2,449	2,442	2,566	2,392
-------Clonidine Hcl	$78,224	$73,214	$68,013	296	280	258	283	274	258
-------Kapvay	$35,222	$32,643	$26,865	97	85	68	88	79	64
-------Catapres-Tts-1	$1,543	$1,524	$1,736	8	8	9	8	7	9
-------Catapres-Tts-3	$6,238	$5,259	$4,011	14	12	9	12	10	9
-------Catapres-Tts-2	$2,183	$2,401	$1,934	8	8	6	6	8	6
Triamcinolone Topical	$37,909	$43,492	$32,970	3,051	2,868	2,639	2,978	2,788	2,575
-------Triamcinolone Acetonide Topical	$37,453	$43,175	$32,514	3,049	2,866	2,637	2,976	2,786	2,574
Cefdinir	$131,637	$183,026	$210,401	1,609	2,496	2,577	1,596	2,473	2,541
-------Cefdinir	$131,637	$183,026	$210,401	1,609	2,496	2,577	1,596	2,473	2,541
Cephalexin	$56,830	$63,501	$57,712	2,337	2,503	2,330	2,312	2,481	2,304
-------Cephalexin Monohydrate	$56,830	$63,501	$57,712	2,337	2,503	2,330	2,312	2,481	2,304
Dexmethylphenidate	$362,711	$445,828	$438,209	1,773	2,250	2,182	1,485	1,896	1,867
-------Focalin Xr	$347,858	$427,527	$420,722	1,436	1,823	1,753	1,356	1,723	1,692
-------Dexmethylphenidate Hydrochloride	$12,504	$15,743	$15,353	292	385	387	279	369	379
-------Focalin	$2,349	$2,558	$2,134	45	42	42	43	39	42
Ondansetron	$132,541	$120,572	$211,166	1,463	1,864	2,168	1,430	1,816	2,126
-------Ondansetron Hydrochloride	$132,541	$120,572	$210,721	1,463	1,864	2,167	1,430	1,816	2,125
Ethinyl Estradiol-Norgestimate	$104,829	$95,574	$80,439	2,740	2,651	2,160	2,577	2,489	2,134

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

Detail Resource Utilization Report - Top 25 Drugs by Number of Claims Last Month

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
-------Trinessa	$16,173	$13,732	$13,635	500	475	424	464	442	418
-------Ortho Tri-Cyclen Lo	$50,241	$46,429	$35,012	588	557	397	561	534	394
-------Tri-Sprintec	$7,605	$6,448	$6,425	416	395	354	389	374	351
-------Sprintec	$5,410	$5,864	$4,730	286	327	252	270	303	248
-------Mononessa	$7,877	$6,558	$6,344	259	243	218	247	225	217
-------Tri-Previfem	$5,024	$4,183	$4,195	147	139	128	141	130	128
-------Tri-Linyah	$3,910	$3,772	$3,352	118	127	100	113	118	98
-------Ortho Tri-Cyclen	$2,163	$2,821	$1,850	165	145	94	162	143	93
-------Ethinyl Estradiol-Norgestimate	$1,880	$1,870	$1,411	79	79	59	74	72	59
-------Ortho-Cyclen	$1,336	$1,301	$1,044	71	64	50	69	64	50
-------Previfem	$1,771	$1,495	$1,399	61	57	48	53	53	47
-------Mono-Linyah	$1,440	$1,103	$1,042	50	43	36	49	40	36
Risperidone	$202,431	$143,258	$176,419	1,997	1,988	1,822	1,757	1,772	1,666
-------Risperidone	$197,204	$138,667	$170,168	1,992	1,983	1,815	1,752	1,769	1,660
-------Risperdal Consta	$4,777	$4,591	$5,801	4	5	6	4	4	5

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

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

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
Montelukast	$1,322,187	$1,590,710	$1,470,795	7,073	8,410	7,467	6,938	8,319	7,407
-------Singulair	$1,322,187	$1,590,710	$1,470,795	7,073	8,410	7,467	6,938	8,319	7,407
Lisdexamfetamine	$919,552	$1,123,952	$1,111,275	4,409	5,446	5,318	4,211	5,269	5,185
-------Vyvanse	$919,552	$1,123,952	$1,111,275	4,409	5,446	5,318	4,211	5,269	5,185
Methylphenidate	$649,709	$736,745	$709,444	3,924	4,445	4,250	3,575	4,093	3,955
-------Methylphenidate Hydrochloride Er	$457,125	$480,880	$437,126	2,744	2,892	2,638	2,592	2,753	2,549
-------Quillivant Xr	$78,869	$108,485	$117,610	327	460	482	316	451	474
-------Metadate Cd	$57,084	$75,746	$84,869	241	324	363	226	311	350
-------Daytrana	$42,710	$46,683	$50,121	179	195	207	171	188	205
-------Methylphenidate Hydrochloride	$7,003	$12,843	$8,771	402	523	516	385	500	495
-------Methylin	$5,456	$9,095	$5,687	15	28	15	15	27	15
-------Concerta	$487	$1,305	$3,378	2	6	11	2	5	11
-------Ritalin La	$399	$1,165	$1,199	2	6	6	2	5	4
-------Methylphenidate Hydrochloride Sr	$513	$435	$619	11	9	11	10	9	11
Antihemophilic Factor	$890,717	$681,959	$672,833	39	40	42	21	26	30
-------Advate Rahf-Pfm	$725,850	$448,826	$431,030	26	24	25	14	17	20
-------Recombinate	$125,842	$137,618	$141,511	10	10	11	5	5	6
-------Kogenate Fs With Bioset	$33,132	$33,132	$34,876	1	1	2	1	1	1
-------Hemofil-M	$0	$0	$34,043	0	0	1	0	0	1
-------Helixate Fs	$5,893	$25,459	$31,373	2	4	3	1	2	2
Aripiprazole	$722,993	$699,681	$633,441	1,141	1,119	999	1,027	1,039	940

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

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

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
-------Abilify	$714,518	$694,741	$627,402	1,134	1,114	993	1,023	1,036	935
-------Abilify Discmelt	$7,252	$3,820	$4,410	6	4	5	5	3	5
-------Abilify Maintena	$1,222	$1,120	$1,628	1	1	1	1	1	1
Budesonide	$437,760	$591,783	$585,384	986	1,403	1,329	966	1,383	1,317
-------Pulmicort Respules	$423,297	$572,736	$566,887	911	1,298	1,245	893	1,280	1,238
-------Pulmicort Flexhaler	$11,631	$15,877	$12,431	72	100	79	71	100	78
-------Budesonide	$2,832	$3,170	$4,748	3	5	4	3	5	4
-------Uceris	$0	$0	$1,319	0	0	1	0	0	1
Amphetamine-Dextroamphetamine	$535,291	$607,408	$582,956	3,386	3,901	3,654	2,840	3,297	3,207
-------Adderall Xr	$443,288	$515,084	$488,803	1,860	2,230	2,076	1,736	2,086	1,990
-------Amphetamine-Dextroamphetamine	$91,854	$92,324	$93,517	1,525	1,671	1,575	1,378	1,534	1,485
-------Adderall	$149	$0	$637	1	0	3	1	0	3
Anti-Inhibitor Coagulant Complex	$351,195	$279,192	$572,514	2	3	4	2	3	3
-------Feiba Nf	$351,195	$279,192	$572,514	2	3	4	2	3	3
Mometasone Nasal	$440,818	$559,288	$527,384	2,633	3,155	2,871	2,615	3,143	2,870
-------Nasonex	$440,818	$559,288	$527,384	2,633	3,155	2,871	2,615	3,143	2,870
Guanfacine	$543,727	$552,021	$520,268	3,085	3,266	3,066	2,912	3,106	2,965
-------Intuniv	$523,737	$530,439	$499,049	1,732	1,798	1,651	1,640	1,714	1,615
-------Guanfacine Hydrochloride	$19,991	$21,582	$21,219	1,353	1,468	1,415	1,282	1,407	1,362
Somatropin	$453,024	$489,350	$459,962	129	130	119	120	126	116
-------Norditropin Flexpro Pen	$105,486	$117,203	$117,918	40	37	37	38	37	36

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

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

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
-------Genotropin	$94,578	$97,542	$111,254	19	19	19	17	19	17
-------Nutropin Aq Nuspin 20	$110,915	$114,931	$87,802	22	22	18	22	22	18
-------Nutropin Aq Nuspin 10	$76,004	$89,091	$78,366	26	29	24	24	28	24
-------Genotropin Miniquick	$39,344	$51,677	$39,486	10	12	11	10	11	11
-------Saizen	$10,746	$0	$11,340	1	0	1	1	0	1
-------Nutropin Aq Pen 20 Cartridge	$5,356	$5,356	$5,648	1	1	1	1	1	1
-------Nutropin Aq Pen 10 Cartridge	$5,389	$4,530	$3,770	4	3	2	2	2	2
-------Nutropin Aq Nuspin 5	$4,476	$1,793	$3,770	2	1	2	2	1	2
Albuterol	$359,918	$564,692	$448,022	6,867	11,385	9,389	5,925	9,891	8,261
-------Proventil Hfa	$227,876	$253,434	$172,822	3,253	3,543	2,483	3,190	3,473	2,452
-------Albuterol Sulfate	$88,433	$146,500	$144,742	2,808	4,915	4,519	2,724	4,790	4,405
-------Ventolin Hfa	$29,466	$99,440	$81,052	559	1,821	1,534	544	1,798	1,524
-------Proair Hfa	$13,815	$64,844	$49,107	235	1,091	842	232	1,079	835
Dexmethylphenidate	$362,711	$445,828	$438,209	1,773	2,250	2,182	1,485	1,896	1,867
-------Focalin Xr	$347,858	$427,527	$420,722	1,436	1,823	1,753	1,356	1,723	1,692
-------Dexmethylphenidate Hydrochloride	$12,504	$15,743	$15,353	292	385	387	279	369	379
-------Focalin	$2,349	$2,558	$2,134	45	42	42	43	39	42
Quetiapine	$474,378	$440,572	$396,984	1,074	1,027	914	875	865	797
-------Seroquel	$374,269	$353,514	$325,605	906	873	786	735	731	678
-------Seroquel Xr	$94,929	$83,977	$68,914	160	150	124	143	132	118
-------Quetiapine Fumarate	$5,181	$3,081	$2,466	8	4	4	7	4	4

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

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
Amoxicillin-Clavulanate	$189,287	$226,387	$271,411	3,041	4,472	4,338	2,999	4,411	4,273
-------Amoxicillin-Clavulanate	$183,741	$218,295	$266,356	3,035	4,462	4,332	2,994	4,401	4,267
-------Augmentin	$5,547	$8,092	$4,061	6	10	5	6	10	5
-------Augmentin Xr	$0	$0	$995	0	0	1	0	0	1
Azithromycin	$131,235	$239,004	$250,994	4,024	8,236	7,639	3,965	8,106	7,530
-------Azithromycin	$108,210	$194,204	$212,131	3,025	5,988	5,962	2,985	5,896	5,881
-------Azithromycin 5 Day Dose Pack	$22,266	$42,462	$36,991	965	2,144	1,601	953	2,129	1,588
-------Azithromycin 3 Day Dose Pack	$758	$2,338	$1,871	34	104	76	33	103	75
Cetirizine	$203,648	$228,993	$238,468	11,003	13,783	12,973	10,820	13,622	12,872
-------Cetirizine Hydrochloride	$201,312	$225,584	$236,373	10,770	13,481	12,705	10,593	13,329	12,605
-------All Day Allergy	$1,750	$2,651	$1,548	190	251	224	188	247	223
-------All Day Allergy Children's	$586	$758	$548	43	51	44	42	51	44
Fluticasone-Salmeterol	$220,287	$248,463	$220,285	760	876	768	744	863	760
-------Advair Diskus	$179,691	$203,721	$180,498	633	734	642	621	723	635
-------Advair Hfa	$40,596	$44,742	$39,788	127	142	126	124	140	125
Ondansetron	$132,541	$120,572	$211,166	1,463	1,864	2,168	1,430	1,816	2,126
-------Ondansetron Hydrochloride	$132,541	$120,572	$210,721	1,463	1,864	2,167	1,430	1,816	2,125
Cefdinir	$131,637	$183,026	$210,401	1,609	2,496	2,577	1,596	2,473	2,541
-------Cefdinir	$131,637	$183,026	$210,401	1,609	2,496	2,577	1,596	2,473	2,541
Sofosbuvir	$118,276	$142,795	$206,982	4	5	7	3	5	7
-------Sovaldi	$118,276	$142,795	$206,982	4	5	7	3	5	7

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

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

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
Epinephrine	$234,933	$356,250	$197,248	652	1,010	545	647	1,003	544
-------Epipen Jr 2-Pak	$130,512	$196,070	$103,165	361	555	283	360	553	283
-------Epipen 2-Pak	$104,415	$160,181	$94,083	290	455	262	290	451	262
Insulin Glargine	$201,662	$199,013	$179,526	553	549	489	517	522	476
-------Lantus	$136,796	$133,974	$116,990	384	387	332	360	366	325
-------Lantus Solostar Pen	$64,866	$65,039	$62,536	169	162	157	160	158	156
Risperidone	$202,431	$143,258	$176,419	1,997	1,988	1,822	1,757	1,772	1,666
-------Risperidone	$197,204	$138,667	$170,168	1,992	1,983	1,815	1,752	1,769	1,660
-------Risperdal Consta	$4,777	$4,591	$5,801	4	5	6	4	4	5
Olanzapine	$191,617	$145,956	$168,022	380	418	348	272	308	278
-------Olanzapine	$168,854	$145,538	$167,845	341	409	344	245	304	276

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

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

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes
Anti-Inhibitor Coagulant Complex	$351,195	$279,192	$572,514	2	3	4	2	3	3
Lisdexamfetamine	$919,552	$1,123,952	$1,111,275	4,409	5,446	5,318	4,211	5,269	5,185
Montelukast	$1,322,187	$1,590,710	$1,470,795	7,073	8,410	7,467	6,938	8,319	7,407
Budesonide	$437,760	$591,783	$585,384	986	1,403	1,329	966	1,383	1,317
Azithromycin	$131,235	$239,004	$250,994	4,024	8,236	7,639	3,965	8,106	7,530
Sofosbuvir	$118,276	$142,795	$206,982	4	5	7	3	5	7
Albuterol	$359,918	$564,692	$448,022	6,867	11,385	9,389	5,925	9,891	8,261
Mometasone Nasal	$440,818	$559,288	$527,384	2,633	3,155	2,871	2,615	3,143	2,870
Amoxicillin-Clavulanate	$189,287	$226,387	$271,411	3,041	4,472	4,338	2,999	4,411	4,273
Cefdinir	$131,637	$183,026	$210,401	1,609	2,496	2,577	1,596	2,473	2,541

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

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

Generic Molecule	Jul 2014 $ Paid	Aug 2014 $ Paid	Sep 2014 $ Paid	Jul 2014 # Claims	Aug 2014 # Claims	Sep 2014 # Claims	Jul 2014 # Benes	Aug 2014 # Benes	Sep 2014 # Benes	Incr. # Claims
Brompheniramine/ Dextromethorph/Phenylephrine	$20,926	$71,547	$54,789	2,496	6,678	6,635	2,461	6,589	6,532	4,139
Azithromycin	$131,235	$239,004	$250,994	4,024	8,236	7,639	3,965	8,106	7,530	3,615
Amoxicillin	$75,213	$116,742	$107,509	7,163	10,146	9,791	7,036	9,998	9,641	2,628
Albuterol	$359,918	$564,692	$448,022	6,867	11,385	9,389	5,925	9,891	8,261	2,522
Cetirizine	$203,648	$228,993	$238,468	11,003	13,783	12,973	10,820	13,622	12,872	1,970
Prednisolone	$53,687	$92,728	$80,839	3,245	5,767	5,032	3,165	5,619	4,901	1,787
Amoxicillin-Clavulanate	$189,287	$226,387	$271,411	3,041	4,472	4,338	2,999	4,411	4,273	1,297
Brompheniramine-Phenylephrine	$8,109	$19,297	$14,601	760	1,821	1,795	753	1,806	1,770	1,035
Cefdinir	$131,637	$183,026	$210,401	1,609	2,496	2,577	1,596	2,473	2,541	968
Lisdexamfetamine	$919,552	$1,123,952	$1,111,275	4,409	5,446	5,318	4,211	5,269	5,185	909

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

Special Reports

ANTIPSYCHOTIC QUALITY MEASURES: METABOLIC MONITORING IN CHILDREN TAKING ANTIPSYCHOTICS

BACKGROUND

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

Antipsychotic medication use is an area of interest for measures development given their increased use in children and adolescents and potentially harmful health effects. While these medications offer the potential for effective treatment of psychiatric disorders, they can also increase a child's risk for developing health concerns such as metabolic and physical complications. Working in coordination with MEDNET, another AHRQ-funded effort to promote quality, NCQA developed a set of measures assessing the use of antipsychotic medications in a general population of children as well as those in the foster care system. The measures will be considered for use by state and federal programs.

Importance

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

Despite these concerns, a study of Medicaid-enrolled children in three states found that only 31 percent of youth starting an atypical antipsychotic received a glucose test[4]. Monitoring of metabolic indices is important to ensure the appropriate management of side effect risk, especially in children and adolescents.

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[2] Pringsheim T, Lam D, Ching H, Patten S. Metabolic and neurological complications of second-generation antipsychotic use in children: a systematic review and meta-analysis of randomized controlled trials. Drug Saf. 2011 Aug 1;34(8):651-68. doi: 10.2165/11592020-000000000-00000. Review. PubMed PMID: 21751826.

[3] Andrade S, Lo J, Roblin D, Fouyazi H, Connor D, Penfold R, Chandra M, Reed G, Gurwitz J. (2011) antipsychotic medication use antipsychotic medication use among children and risk of diabestes mellitus. Pediatrics, 128, 1135-1141.

[4] Morrato E, Nicol G, Maahs D, Druss B, Hartung D, Valuck R et al. (2010). Metabolic screening in children receiving antipsychotic drug treatment. Arch Pediatr Adolesc Med, 164, 344-351.

Several AACAP practice parameters (including for treatment of schizophrenia and for the use of psychotropic medication) as well as the TRAAY guidelines (Treatment Recommendations for the Use Antipsychotics for Aggression in Youth, Part II, 2003) recommend careful monitoring of side effects. The Canadian Alliance for Monitoring Safety and Effectiveness of Antipsychotics in Children recently published evidence-based guidelines for metabolic and neurological monitoring of children prescribed atypical antipsychotics. Given the documented metabolic risks of antipsychotic medications, the monitoring of metabolic indices is important to ensure appropriate management of side effect risk, especially in children and adolescents.

Previous studies have shown that children prescribed antipsychotic medications have a higher risk of diabetes compared to children not prescribed these medicines. Monitoring of metabolic indices such as glucose level and cholesterol level is important to ensure the appropriate management of risk of side effects in the children and adolescents who are prescribed antipsychotic medicines. The current report focuses on the National Collaborative for Innovation in Quality Measurement (NCINQ) measure - metabolic screening for children on antipsychotics.

METHODS

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

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

The recommended measure included three numerators.

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

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

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

RESULTS

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

Table 1: Metabolic Monitoring in Children Taking Antipsychotics		
	Total Number of Beneficiaries (N= 8,912)	
	No of Beneficiaries	Percentage of Beneficiaries
Blood glucose test	2669	29.9%
Cholesterol test	1261	14.1%
Both tests	1162	13.0%

In the NCINQ call for comments, they presented preliminary results for the proposed quality measures based on performance for 11 states using the Medicaid Analytic Extract files from 2008. Their preliminary results for the metabolic monitoring measure are reported in Table 2. Based on the rates provided by NCINQ, The Mississippi Medicaid program is currently performing just above the 25th percentile on this quality measure.

Table 2: Preliminary Results From NCINQ Analysis of 11 State Medicaid Programs (2008 data)							
		Distribution Across 11 States					
Measure	Overall Performance	Minimum	25th Percentile	Median	Mean	75th Percentile	Max
Blood glucose test	34.3%	11.8%	29.6%	36.8%	33.1%	38.0%	42.1%
Cholesterol test	18.9%	7.3%	13.3%	17.9%	18.2%	19.3%	33.8%
Both tests	17.5%	3.9%	12.6%	17.0%	16.4%	17.8%	32.7%

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

Table 3 : Percent of Children Taking Antipsychotics Receiving Metabolic Monitoring By Health Plan								
	FFS (Denominator = 6,163)		**UHC (Denominator = 1,101)**			**Magnolia (Denominator = 1,648)**		
Measure	Beneficiaries Having Test		Beneficiaries Having Test			Beneficiaries Having Test		
Blood glucose test	1,867	30.3%	311	28.3%		491	29.8%	
Cholesterol test	892	14.5%	138	12.5%		231	14.0%	
Both tests	824	13.4%	126	11.4%		212	12.9%	

Table 4 shows performance rates for each plan broken down by age of the beneficiary. Again, performance rates did not meaningfully differ among the plans. Use of metabolic monitoring tests increases as the beneficiary becomes older. Since a major concern about the metabolic side effects has to do with the age when antipsychotic treatment is started and how long a beneficiary might remain on antipsychotic therapy, it would be ideal if monitoring began at an earlier age. Monitoring for all ages needs to be improved.

Table 4: Percent of Children Taking Antipsychotics Receiving Metabolic Monitoring - By Age and Health Plan

		FFS		UHC		Magnolia	
Measure	**Age Group**	Beneficiaries Taking Antipsychotics (Denominator)	% Having Test	Beneficiaries Taking Antipsychotics (Denominator)	% Having Test	Beneficiaries Taking Antipsychotics (Denominator)	% Having Test
Blood glucose test	<=5	151	22.5%	20	20.0%	40	22.5%
	6-11	2,162	22.4%	303	22.4%	447	19.9%
	12-17	3,267	34.0%	475	26.9%	763	30.0%
	18-20	583	41.0%	303	36.6%	398	41.2%
Cholesterol test	<=5	151	8.6%	20	5.0%	40	7.5%
	6-11	2,162	9.0%	303	9.6%	447	8.9%
	12-17	3,267	17.9%	475	14.1%	763	16.0%
	18-20	583	16.8%	303	13.5%	398	16.6%
Both tests	<=5	151	7.9%	20	5.0%	40	7.5%
	6-11	2,162	8.2%	303	8.6%	447	7.8%
	12-17	3,267	16.7%	475	12.2%	763	14.8%
	18-20	583	15.4%	303	13.5%	398	15.3%

CONCLUSION

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

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

Recommendation:

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

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

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

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

APPENDIX

TABLE 1: Antipsychotic Medications
Any 1st Generation Antipsychotic Medications
chlorpromazine hcl
fluphenazine hcl
fluphenazine decanoate
fluphenazine enanthate
haloperidol
haloperidol decanoate
haloperidol lactate
loxapine hcl
loxapine succinate
molindone hcl
perphenazine
pimozide
promazine hcl
thioridazine hcl
thiothixene
thiothixene hcl
trifluoperazine hcl
triflupromazine hcl
Any 2nd Generation Antipsychotic Medications
aripiprazole
clozapine
iloperidone
olanzapine
olanzapine pamoate
paliperidone
paliperidone palmitate
quetiapine fumarate
risperidone
risperidone microspheres
ziprasidone hcl
ziprasidone mesylate
Combinations
Olanzapine-fluoxetine hcl (Symbyax)
Perphenazine-amitriptyline hcl (Etrafon, Triavil (various))

TABLE 2: Glucose Laboratory Screening Tests Codes	
CPT Code	Code Description
80047	From SSD HEDIS Measure
80048	Basic metabolic panel
80050	General health panel
80053	Comprehensive metabolic panel
80069	From SSD HEDIS Measure
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose; quantitative, blood (reagent strip)
82950	Glucose; post glucose dose (includes glucose)
82951	Glucose; tolerance test (GTT), three specimens (includes glucose)
83036	Glycohemoglobin (A1c)
3044F	Most Recent Hemoglobin A1C (HbA1C) Level 7.0% (Dm)2,4
3046F	Most Recent Hemoglobin A1C Level > 9.0% (Dm)
3045F	Most Recent Hemoglobin A1C (HbA1C) Level 7.0 - 9.0 % (Dm)2,4

TABLE 3: Lipid Laboratory Screening Tests Codes	
CPT Code	Code Description
80061	Lipid panel
82465	Cholesterol, serum or whole blood, total
83700	Lipoprotein, blood; electrophoretic separation and quantitation (form. 83715)
83701	Lipoprotein, blood; high resolution fractionation... (form. 83716)
83704	Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (e.g., by nuclear magnetic resonance spectroscopy)
83715	Lipoprotein, blood; electrophoretic separation and quantitation
83716	Lipoprotein, blood; high resolution fractionation...
83721	Lipoprotein, direct measurement, LDL cholesterol
84478	Triglycerides
3048F	Most Recent Ldl-C 100 Mg/Dl (Dm)
3049F	Most Recent Ldl-C 100-129 Mg/Dl (Dm)
3050F	Most Recent Ldl-C Greater Than Or Equal To 130 Mg/Dl (Dm)4

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

BACKGROUND:

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

The Washington State Agency Medical Directors Group has suggested 120mg MED as a dosage level that should not be exceeded without special consideration.[4] Additionally, CMS' controlled substance overutilization monitoring system (OMS) for the Medicare Part D program currently identifies potential outlier opioid utilization issues at the beneficiary level using the following criteria: 'Excluding patients with cancer or receiving hospice care, beneficiaries whose daily MED is greater than 120mg for at least 90 consecutive days, and who used more than 3 prescribers and more than 3 pharmacies.[5, 6]

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

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[1] Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose. Ann Intern Med 2010;152:85–92.

[2] Bohnert AS, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. JAMA 2011;305:1315–21.

[3] PQA Medication Safe Use Workgroup. Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer.

[4] Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An educational aid to improve care and safety with opioid therapy. Available at: http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf Accessed on: Jan 15, 2014.

[5] Memorandum: Medicare Part D Overutilization Monitoring System. Available at: http://www.amcp.org/uploadedFiles/Production_Menu/Policy_Issues_and_Advocacy/Letters,_Statements_and_Analysis_-_docs/2013/OMS%20HPMS%20Announcement%20Memo_FINAL_070513.pdf Accessed on: Jan 15, 2014.

[6] CMS Announces Medicare Part D Overutilization Monitoring System (OMS) for Controlled Substances. Available at: http://www.amcp.org/uploadedFiles/Production_Menu/Policy_Issues_and_Advocacy/Letters,_Statements_and_Analysis_-_docs/2013/CMS_OMS_July2013_Letterhead_Final.pdf Accessed on: Jan 15, 2014.

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

Using a combination of these measures to identify beneficiaries at risk of opioid overuse or abuse/diversion was reviewed with the MS-DUR Board in November 2012 and February 2014. MS-DUR is still working with DOM Program Integrity to develop better methods of identifying potential abuse or diversion. Based on growing concerns about preventing opioid related deaths due to high doses, MS-DUR reran analyses focusing on Measure 1 – high-dose utilization. This is a clinical safety issue that could be addressed through prospective clinical edits, whereas, the multiple provider measures are not easily addressed prospectively. The purpose of this analysis was to determine the number of beneficiaries who are possibly over-utilizing opioid medications in the Medicaid population and are at-risk for opioid addiction or death.

METHODS:

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

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

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

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

RESULTS:

As shown in Table 1, each Medicaid plan (Medicaid fee-for-service (FFS), United Health Care (UHC), and Magnolia) had a large number of beneficiaries with 2 or more prescription claims for opioids during the study year and not having a cancer diagnosis.

TABLE 1: Number of Beneficiaries Meeting Inclusion Criteria for Analysis (Denominator)

#	DESCRIPTION	UNIQUE BENEFICIARIES IN FFS	UNIQUE BENEFICIARIES IN UHC	UNIQUE BENEFICIARIES IN MAGNOLIA
1.	Beneficiaries with a Rx claim of an opioid medication	5,428	13,194	17,445
2.	Beneficiaries with ≥ 2 prescription claims with ≥ 15 days supply for an opioid medication, on at least two separate dates	3,063	7,657	10,213
3.	After excluding beneficiaries in LTC	2,648	7,657	10,213
4.	After excluding beneficiaries with a diagnosis of cancer within 6 months of the study start date (i.e., July 1, 2013)	**2,475**	**7,483**	**9,933**

LTC: Long-term Care

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

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

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

*Example: (51/2475)*100 = 2.1%

CONCLUSION:

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

Recommendations:

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

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

APPENDIX A

From Acumen LLC July 2013
Patient Safety Analysis PDP/MA-PD Contracts
Overutilization Monitoring System User Guide

Table Opioid Morphine Equivalent Conversion Factors[1]

Type of Opioid	Morphine Equivalent Conversion Factor	Included in 2012 CMS?
buprenorphine patch[2]	42	No
buprenorphine tab or film	10	No
butorphanol	7	No
codeine	0.15	Yes
dihydrocodeine	0.25	Yes
fentanyl buccal or SL tablets, or lozenge/troche[3]	0.13	Yes
fentanyl film or oral spray[4]	0.18	Yes
fentanyl nasal spray[5]	0.16	Yes
fentanyl patch[6]	7.2	Yes
hydrocodone	1	Yes
hydromorphone	4	Yes
levorphanol tartrate	11	Yes
meperidine hydrochloride	0.1	Yes
methadone	3	Yes
morphine	1	Yes
nalbuphine	1	No
opium	1	No
oxycodone	1.5	Yes
oxymorphone	3	Yes

pentazocine	0.37	No
tapentadol	0.4	No
tramadol	0.1	No

[1]Center for Disease Control and Prevention, Morphine equivalent conversion factors for opioids, 2011 version CDC, Atlanta, GA, 2013.
[2]MME conversion factor for buprenorphine patches is 42 based on 15% bioavailability compared with IV buprenorphine, which is 40 times the strength of morphine and the use of such patches for 7 days. In other words, 40 x 0.15 x 7 = 42
[3]MME conversion factor for fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. It is intended to be multiplied by the number of micrograms in a given lozenge/troche
[4]MME conversion factor for fentanyl film and oral spray is 0.18 (based on 40% greater exposure compared to lozenge for film and 38% greater compared to lozenge for oral spray).
[5]MME conversion factor for fentanyl nasal spray is 0.16 (based on 20% greater exposure compared to lozenge for nasal spray
[6]The MME conversion factor for fentanyl patches is 2.4, but each patch is usually worn for 3 days. Since daily dosage is calculated by multiplying pill size in MME by number of pills and then dividing by number of days prescribed, failure to account for the long use of each patch would underestimate daily dosage. For example, 10 patches dispensed for use over 30 days would be (10 x 2.4)/30. Multiplying the conversion factor by 3 accounts for the prolonged use of a patch. Therefore, the conversion factor is given as 7.2.

CMS Morphine Equivalent Dose (MED) Calculation[7]

- Prescription for oxycodone 5mg 1-2 tablets every 4-6 hours as needed quantity **#60**
- Pharmacist enters days supply = **5** (could take up to 12 tablets in 24 hour period)
- Number of opioid dosage units per day = $\frac{Submitted\ Quantity}{Days\ Supply} = \frac{60}{5} = \mathbf{12}$
- **Oral MED Daily Dose Per Claim:**
  $= Number\ of\ Opioid\ Units\ per\ Day\ \times Strength\ \times MME\ Conversion\ Factor$
  $= 12\ \times 5\ \times 1.5$
  $= 90$

[7] AMCP 2013 Nexus. Research Briefs: Identifying and Managing Controlled Substance Abuse.

USE OF CONTRACEPTIVE PRODUCTS IN MISSISSPPI MEDICAID FAMILY PLANNING WAIVER PROGRAM

BACKGROUND

In recent years, several states have expanded eligibility for Medicaid coverage of family planning services. Historically, states like MS have secured approval of a "waiver" of federal policy from the Centers for Medicare and Medicaid Services. Traditionally, MS Medicaid's Family Planning Program has been solely for women receiving family planning benefits. State Medicaid programs participating in the Family Planning, Access, Care and Treatment (FPACT) Program receive a 90% federal match for contraceptives used for family planning/birth control purposes. Contraceptives prescribed to family planning waiver beneficiaries for indications other than family planning, including but not limited to acne vulgaris, menorrhagia, premenstrual dysphoric disorder are entitled to the state's federal medical assistance percentage (FMAP) rate rather than the enhanced or 90% match. Department of Health and Human Services Office of the Inspector General (OIG) is auditing states participating in the FPACT program for submitting contraceptive claims at the enhanced match rate when documentation was lacking that the medication was prescribed for family planning purposes. In many cases, the OIG has recommended that state Medicaid programs reimbursement to CMS, for the difference in state federal match and contraceptive enhanced match, as well as develop a policy to improve monitoring and control over billing for enhanced federal match process.

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

METHODS

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

periods of 90 days, 365 days and 730 days would affect the percentage of oral contraceptive claims that could be documented as being for contraceptive use or other treatments.

RESULTS

Table 1 shows the percentage of beneficiaries taking oral contraceptives that had documentation of the treatments described above. As would be expected, the percentage of beneficiaries with a documented diagnosis increased as the length of the look-back period increased. Even with a two-year look-back period, only about one-fourth of the beneficiaries taking oral contraceptives had documentation of contraceptive counseling. The prevalence of documentation was similar across all three plans.

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

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

** A contraceptive counseling procedure code is required to document use for birth control.*

*** Look-back is from first oral contraceptive fill in 2014.*

CONCLUSIONS

Even with a two-year look-back period, only a small percentage of oral contraceptive use could be documented as being for birth control. Although the claims processing system can do a two-year look-back, contraceptive counseling should be expected more often. In order to maximize the

number of contraceptive claims that qualify for the higher FMAP rate, DUR initiatives need to be undertaken to assure documentation of medical use for contraceptives.

RECOMMENDATION:

1. DOM should implement an electronic prior authorization clinical edit for all contraceptives (oral, injectable, or implant) requiring a diagnosis code for counseling and advice on contraceptive management (V 25.0x) or surveillance of previously prescribed contraceptive methods (V25.4x) be found in the medical claims history within one (1) year of a prescription being filled or the diagnosis must be written on the prescription by the prescribing physician and entered by the pharmacy at the time of dispensing.

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

WEIGHT CONTROL MEDICATION CLINICAL EDIT

BACKGROUND

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

Although Contrave® has only been on the market since September, early published information could have already resulted in physicians prescribing the two active ingredients in order to treat weight loss in Medicaid patients.

METHODS

MS-DUR conducted an analysis of prescriptions for naltrexone and bupropion since January 2014 in order to determine if any combination use has already occurred. A retrospective analysis was conducted using Mississippi Medicaid FFS and MSCan pharmacy claims for the period January 1, 2014 through October 15, 2014. All prescriptions for naltrexone and bupropion were extracted and beneficiaries were identified if concomitant use of both products occurred.

RESULTS

Naltrexone was taken by only a few beneficiaries in each plan. As would be expected, bupropion was more heavily used. Only one case was identified where naltrexone was taken concomitantly with bupropion. This patient had been on bupropion all year and had naltrexone added in April for one month.

TABLE 1: NUMBER OF BENEFICIARIES TAKING NALTREXONE AND BUPROPION BY PLAN			
	FFS	UHC	Magnolia
Naltrexone	40	7	10
Bupropion	773	1090	1523
Both	0	1	0

CONCLUSIONS

To date, there only appears to be one case where naltrexone and bupropion were taken concomitantly. Since prescriptions do not require a diagnosis be recorded, it cannot be determined why naltrexone was prescribed for this beneficiary. Even though there is no evidence that concomitant use of these products will be a big problem, MS-DUR recommends that DOM go ahead and implement the clinical edit suggested by Xerox since eliminating the potential for concomitant use is relatively easy and will not result in a significant number of manual prior authorization requests if the concomitant use is medically justified for treatment of conditions for which the two agents are covered by DOM.

RECOMMENDATION

DOM should implement a clinical edit to prevent naltrexone and bupropion being used in combination. If medically necessary, concomitant use would have to be approved through manual prior authorization.

Exceptions Monitoring Criteria Recommendations

MISSISSIPPI MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
EXCEPTIONS MONITORING CRITERIA RECOMMENDATIONS

Criteria Recommendations

1. Maximum Recommended Dosage for Alsuma

Message: In June 2014, the FDA approved labeling changes for Alsuma to include that the maximum recommended dose that may be given in 24 hours is two doses of Alsuma separated by at least 1 hour.

Exception Type: IDO – Innappropriate dose (high dose alert)

Reference:
FDA Drug Safety Communications 2014. Available at:
http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm403250.htm

2. Coadministration of Sporanox capsules contraindicated with a number of CY P3A4 substrates

Message: In June 2014, the FDA approved labeling changes listing the following contraindications with concomitant usage of Sporanox. These drugs with coadministration of itraconazole may increase or prolong the pharmacologic effect and/or the adverse reactions of these drugs.

Exception Type: DDI - drug-drug interaction

Field Type 1	Field Type 2	
Sporanox	Methadone	Pimozide
	Disopyramide	Triazolam
	Dofetilide	Felodipine
	Dronedarone	Nisoldipine
	Quinidine	Ranolazine
	Ergot alkaloids	Eplerenone
	Ergotamine	Cisapride
	Methylergometrine	Lovastatin
	Irinotecan	Simvastatin
	Lurasidone	Colchicine
	Oral midazolam	

Reference:
FDA Drug Safety Communications 2014. Available at:
http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm303524.htm

3. Updated Linzess age documentation

Message: In July 2014, the FDA approved labeling changes stating that Linzess is contraindicated in patients under six years of age.

Exception Type: CAP – clinical appropriateness (age restriction)

Field Type 1	Field Type 2
Linzess	Patients under 6 years of age

References:
FDA Drug Safety Communications 2014. Available at:
http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm409253.htm

4. Revlimid can cause increased risk of health issues

Message: In 2014, the FDA approved labeling changes for Revlimid stating an increased risk for deep vein thrombosis, pulmonary embolism, myocardial infarction, and stroke in patients with multiple myeloma receiving Revlimid with dexamethasone

Exception Type: DDI – drug-drug interaction (disease specific)

Field Type 1	Field Type 2
Revlimid	dexamethasone and multiple myeloma

References:
FDA Drug Safety Communications 2014. Available at:
http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm299519.htm

5. Life threatening and fatal events in infants and young children with use of Xylocaine

Message: In 2014, the FDA approved labeling changes for Xylocaine Viscous Solution to include their recommendation to not use in patiens less than 3 years old due to an increased reported incidence of seizures, cardiopulmonary arrest and death.

Exception Type: CAP – clinical appropriateness (age restriction)

Field Type 1	Field Type 2
Xylocaine Viscous Solution	Patients under 3 years of age

References:
FDA Drug Safety Communications 2014. Available at:
http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm417582.htm