MEDICAID DRUG UTILIZATION REVIEW ANNUAL REPORT

FEDERAL FISCAL YEAR_____

Section 1927 (g) (3) (D) of the Social Security Act (the Act) requires each State to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program. Such reports are to include:
descriptions of the nature and scope of the prospective and retrospective DUR programs; a summary of the interventions used in retrospective DUR and an assessment of the education program; a description of DUR Board activities; and an assessment of the DUR program's impact on quality of care as well as any cost savings generated by the program.

This report covers the period October 1, _____to September 30,_____and is **due for submission to CMS Central- Office by no later than June 30,_____. Answering the attached questions and returning the requested materials as attachments to the report will constitute compliance with the above- mentioned statutory requirement.**

If you have any questions regarding ~~this survey instrument or~~ the DUR Annual Report, please contact CMS: DURPolicy@cms.hhs.gov.

MEDICAID DRUG UTILIZATION REVIEW ANNUAL REPORT

FEDERAL FISCAL YEAR _____

I. DEMOGRAPHIC INFORMATION

State Name Abbreviation

_____

Medicaid Agency Information

Identify State person responsible for DUR Annual Report Preparation.

Name: _____

Email Address: _____

Area Code/Phone Number: _____

II. PROSPECTIVE DUR (ProDUR)

Identify by name and indicate the type of your pharmacy POS vend~~e~~or – (contractor, state-operated other).

_____

1. If not state-operated, is the POS vendor also the MMIS fiscal agent?

   ☐ Yes ☐ No

2. Identify prospective DUR criteria source.

   ☐ First Data Bank ☐ ~~Other~~Medi-~~s~~Span ☐ Other

   If the answer above is "Other," please specify.

   _____

3. Are new prospective DUR criteria approved by the DUR Board?

   ☐ Yes ☐ No

If answer above is "No," please explain.~~:~~

_____

_____

4. When the pharmacist receives a ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "conflict, intervention and outcome" codes?

   ☐ Yes ☐ No

5. How often ~~D~~do you receive and review periodic reports ~~from your ProDUR contractor~~ providing individual pharmacy provider activity in summary and in detail?

   ☐ M~~m~~onthly ☐ Q~~q~~uarterly ☐ A~~a~~nnually ☐ Never

   ~~☐ Yes ☐ No~~

   a) ~~If answer above is "Yes," how often is the report received by the agency:~~ If the answer above is "Never," please explain why you do not receive and review the reports.

   _____

   _____

   ~~a~~b) If you receive reports, do you follow-up with those providers who routinely override with interventions?

   ☐ Yes ☐ No

   c) ~~b)~~ If the answer to (b) above is "Yes," by what method do you follow-up?

   ☐ Contact P~~p~~harmacy
   ☐ Refer to Program Integrity for Review
   ☐ Other. ~~(~~please explain~~).~~

   _____

   _____

   d) If the answer to (b) above is "No," please explain why you do not follow-up with providers.

   _____

6. Early Refill:

   a) At what percent threshold do you set your system to edit?

      Non-controlled drugs: _____%

      Controlled drugs: _____%

   b) When an early refill message occurs, does the state require prior authorization?

      Non-controlled drugs: ☐ Yes ☐ No

      Controlled drugs: ☐ Yes ☐ No

   c) For non-controlled drugs, if the answer to ~~4~~ (b) above is "Yes," who obtains authorization?

      ☐ Pharmacist ☐ Prescriber ☐ Either

   d) For controlled drugs, if the answer to ~~4~~ (b) above is "Yes," who obtains authorization?

      ☐ Pharmacist ☐ Prescriber ☐ Either

   e) For non-controlled drugs, if the answer to ~~4~~ (b) above is "No," can the pharmacist override at the point of service?

      ☐ Yes ☐ No

   f) For controlled drugs, if the answer to ~~4~~ (b) above is "No," can the pharmacist override at the point of service?

      ☐ Yes ☐ No

7. When the pharmacist receives an early refill DUR alert message that requires the Pharmacist's review, does your ~~system~~ state's policy allow the pharmacist to override for situations such as:

   a) Lost/stolen Rx ☐ Yes ☐ No
   b) Vacation ☐ Yes ☐ No
   c) Other~~.~~: please explain.

8. Does your system have an accumulation edit to prevent patients from ~~obtaining additional refills during the calendar year~~continuously filling prescriptions early?

   ☐ Yes ☐ No

   a) If "Yes," please explain your edit.

b) If "No," do you plan to implement this edit?

☐ Yes ☐ No

9. Does the state or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS?

☐ Yes ☐ No

10~~9~~. Has the state provided the DUR ~~criteria~~ data requested on Table 1 – Top ~~10~~Drug Claims Data Reviewed by the DUR Board ~~Pro DUR Alerts by Problem Type indicating by problem type those criteria with the most significant severity level reviewed by the DUR Board~~~~Has the state completed table X~~?

☐ Yes ☐ No

11. Section 1927(g)(A) of the Social ~~s~~Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in your state has responsibility for monitoring compliance with the oral counseling requirement? Check all that apply:

a) ☐ Medicaid agency
b) ☐ State Board of Pharmacy
c) ☐ Other~~,~~ – please explain.

_____

_____

12. Has the state included **Attachment 1 – Pharmacy Oral Counseling Compliance Report** a report on state efforts to monitor pharmacy compliance with the oral counseling requirement?

☐ Yes ☐ No

III. RETROSPECTIVE DUR (RetroDUR)

1. Identify, by name and type, the vendor that performed your Retro DUR activities during the time period covered by this report (company, academic institution, or other organization).

_____

_____

a) Is the Retro-DUR vendor also the Medicaid fiscal agent?

☐ Yes ☐ No

b) Is the Retro-DUR vendor also the developer/supplier of your retrospective DUR criteria?

☐ Yes ☐ No

If "No," please explain:.

_____

_____

2. Does the DUR Board approve the Retro DUR criteria?

☐ Yes ☐ No

If "No," please explain.

_____

_____

3. Has the state included **Attachment 2 – Retrospective DUR Educational Outreach Summary**, a year end summary of the Top 10 problem types for which educational interventions were taken?

☐ Yes ☐ No

IV. DUR BOARD ACTIVITY

1. State is including a brief summary of DUR Board activities and meeting minutes during the time period covered by this report as **Attachment 3 - Summary of DUR Board Activities.**

☐ Yes ☐ No

2. Does your state have a Disease Management Program?

☐ Yes ☐ No

a) If "Yes," have you performed an analysis of the program's effectiveness?

☐ Yes ☐ No

b) If the answer to (a) above is "Yes," please provide a brief summary of your findings:

_____

c) If the answer to (number 2) above is "Yes," is your DUR Board involved with this program?

☐ Yes ☐ No

3. Does your state have an approved CMS Medication Therapy Management Program?

☐ Yes ☐ No

a) If "Yes," have you performed an analysis of the program's effectiveness?

☐ Yes ☐ No

b) If the answer to (a) above is "Yes," please provide a brief summary of your findings.

c) If the answer to (number 3) above is "Yes," is your DUR Board involved with this program?

☐ Yes ☐ No

d) If the answer to (number 3) above is "No," are you planning to develop and implement a program?

☐ Yes ☐ No

V. PHYSICIAN ADMINISTERED DRUGS

The Deficit Reduction Act required collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your MMIS been designed to incorporate this data into your DUR criteria for: ~~both~~

a) Pro-DUR ~~and Retro DUR~~?

☐ Yes ☐ No

If "No," do you have a plan to include this information in your DUR criteria in the future?

☐ Yes ☐ No

b) Retro-DUR?

☐ Yes ☐ No

If "No," do you have a plan to include this information in your DUR criteria in the future?

☐ Yes ☐ No

VI. GENERIC POLICY AND UTILIZATION DATA

1. State is including a description of policies that may affect generic utilization percentage as **Attachment 4 - Generic Drug Substitution Policies**.

   ☐ Yes ☐ No_____

2. In addition to the requirement that the prescriber write in his/her own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your state have a more restrictive requirement?

   ☐ Yes ☐ No

   If "Yes," check all that apply:

   a) ☐ Require that a MedWatch Form be submitted
   b) ☐ Require medical reason for override accompany prescriptions
   c) ☐ Prior eauthorization is required
   d) ☐ Other, – please explain.

   _____

   _____

3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in **Table 2 - Generic Utilization Data**

   Number of Generic Claims _____

   Total Number of Claims _____

   Generic Utilization Percentage _____

4. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period using the computation instructions in **Table 2 - Generic Utilization Data**

   Generic Dollars: _____

   Total Dollars: _____

   Generic Expenditure Percentage: _____

VII. PROGRAM EVALUATION / COST SAVINGS/COST AVOIDANCE

1. Did your state conduct a DUR program evaluation of the estimated cost savings/cost avoidance?

   ☐ Yes ☐ No

2. Who conducted your program evaluation for the cost savings estimate/cost avoidance? (company, academic institution, other institution) (name)

   _____

3. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below.

ProDUR Total Estimated Avoided Costs	
RetroDUR Total Estimated Avoided Costs	
Other cost avoidance	
Grand Total estimated Avoided Costs	

4. Please provide the estimated percent impact of your state's cost savings/cost avoidance program compared to total drug expenditures for covered outpatient drugs.

   Use the following formula:

   Divide the estimated Grand Total Estimated Avoided Costs from Question 3 above by the total dollar amount provided in Section VI, Question 4. Then multiply this number by 100.

   Grand Estimated Net Savings Amount ÷ Total Dollar Amount × 100 = _____%

5. State has provided the Medicaid Cost Savings/Cost Avoidance Evaluation as **Attachment 5 – Cost Savings/Cost Avoidance Methodology.**

   ☐ Yes ☐ No

VIII. FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTIVE PROGRAMS

1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **beneficiaries**?

   ☐ Yes ☐ No

If "Yes," what actions does this process initiate? Check all that apply.

a) ☐ Deny claims and require prior authorization
b) ☐ Refer to Lock In Program
c) ☐ Refer to Program Integrity Unit
d) ☐ Other (e.g. SURS, Office of Inspector General), please explain.

_____

_____

2. Do you have a "lock-in" program for beneficiaries with potential misuse or abuse of controlled substances?

☐ Yes ☐ No

If "Yes," what criteria does your state use to identify candidates for lock-in? Check all that apply.

☐ Number of controlled substances (CS)
☐ Different prescribers of CS
☐ Multiple pharmacies
☐ Number days' supply of CS
☐ Exclusivity of short acting opioids
☐ Multiple ER visits
☐ Other

If "Yes," do you restrict the beneficiary to:

i. a prescriber only ☐ Yes ☐ No
ii. a pharmacy only ☐ Yes ☐ No
iii. a prescriber and pharmacy ☐ Yes ☐ No

What is the usual "lock-in" time period?

☐ 6 months
☐ 12 months
☐ Other, please explain.

_____

_____

3. On the average, what percentage of the FFS population is in lock-in status annually?

_____%

4. Please provide an estimate of the savings attributed to the lock-in program for the fiscal year under review.

   $_____

5. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by **prescribers**?

   ☐ Yes ☐ No

   If "Yes," what actions does this process initiate? Check all that apply.

   a.) ☐ Deny claims written by this prescriber
   b.) ☐ Refer to Program Integrity Unit
   c.) ☐ Refer to the appropriate Medical Board
   d.) ☐ Other, – please explain:.

   _____

   _____

6. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **pharmacy providers**?

   ☐ Yes ☐ No

   If "Yes," what actions does this process initiate? Check all that apply

   a.) ☐ Deny claim
   b.) ☐ Refer to Program Integrity Unit
   c.) ☐ Refer to Board of Pharmacy
   d.) ☐ Other,— please explain.

   _____

   _____

7. Do you have a documented process in place that identifies potential fraud or abuse of non-controlled drugs by **beneficiaries**?

   ☐ Yes ☐ No

   If "Yes," please explain your program for fraud or abuse of non-controlled substances.

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Does your state have a Prescription Drug Monitoring Program (PDMP)?

☐ Yes ☐ No

a) If the answer above is "Yes," does your agency have the ability to query the state's PDMP database?

☐ Yes ☐ No

b) If the answer to (number 1) above is "Yes," do you require prescribers (in your provider agreement with the agency) to access the
PDMP patient history before prescribing restricted substances?

☐ Yes ☐ No

c) If the answer to (number 1) above is "Yes," please explain how the state applies this information to control fraud and abuse.

d) If the answer to (number 1) above is "Yes," do you also have access to border states' PDMP information?

☐ Yes ☐ No

2. Are there barriers that hinder the agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?

☐ Yes ☐ No

If "Yes," please explain the barriers (e.g. lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).

3. Have you had any changes to your state's Prescription Drug Monitoring Program during this reporting- period that have improved the agency's ability to access PDMP data?

☐ Yes ☐ No

If "Yes," please explain.~~:~~

_____

_____

C. PAIN MANAGEMENT CONTROLS

1. Does your state or your agency require that Pain Management providers be certified?

☐ Yes ☐ No

2 Does your program obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?

☐ Yes ☐ No

a) If the answer above is "Yes," do you apply this DEA file to your ProDUR~~ur~~ POS edits to prevent unauthorized prescribing?

☐ Yes ☐ No

b) If the answer to (a) above is "Yes," please explain how the information is applied.

_____

_____

c) If the answer to (a) above is "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

☐ Yes ☐ No

3. Do you apply this DEA file to your RetroDUR reviews?

☐ Yes ☐ No

If "Yes," please explain how it is applied.

_____

_____

4. Do you have measures in place to either monitor or ~~to~~ manage the prescribing of methadone for pain management?
☐ Yes ☐ No ☐ Other

If "Yes," check all that apply:

☐ P~~p~~harmacist override
☐ D~~d~~eny claim and require PA
☐ Q~~q~~uantity limits
☐ I~~i~~ntervention letters
☐ Morphine equivalent daily dose program
☐ Step therapy or Clinical criteria

If "No" or "Other," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of methadone for pain management.

_____

_____

D. OPIOIDS

1. Do you currently have POS edits in place to limit the quantity of short-acting opioids?

☐ Yes ☐ No

a) If "Yes," what is your maximum daily limit in terms of number of units (i.e. tablets, capsules)?

_____ ☐ units/day

b) If "Yes," what is your maximum days supply per prescription limitation~~s~~?

☐ 30 day supply
☐ 90 day supply
☐ ~~o~~Other, please explain.

_____

2. Do you currently have POS edits in place to limit the quantity of long-acting opioids?

☐ Yes ☐ No

a)If "Yes," what is your maximum daily limit in terms of number of units (i.e. tablets, capsules)?

☐ 2 units/day
☐ 3 units/day

b) If "Yes," what is~~are~~ your maximum days supply per prescription limitation~~s~~?

☐ 30 day supply
☐ 90 day supply
☐ ~~o~~Other, please explain.

3. Do you currently have edits in place to monitor -opioids and benzodiazepines being used concurrently?

☐ Yes ☐ No

If "Yes," please explain.

E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

1. Have you set recommended maximum morphine equivalent daily dose measures?

☐ Yes ☐ No

If "Yes," what is your maximum morphine equivalent daily dose limit in milligrams?

_____mg per day

If "No," please explain the measure or program you utilize.

2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage?

☐ Yes ☐ No

If "Yes," how is the information disseminated?

☐ Wwebsite
☐ Pprovider notice
☐ Eeducational seminar
☐ ~~o~~Other, explain.

_____

_____

3. Do you have an algorithm in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?

☐ Yes ☐ No

F. BUPRENORPHINE and BUPRENORPHINE/NALOXONE COMBINATIONS

1. Does your agency set total mg per~~/ per~~ day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

☐ Yes ☐ No

If "Yes," please specify the total mg/day?

~~☐ 8mg~~☐ 12 mg

☐ ~~12 mg~~ 16 mg
☐ ~~16 mg~~ 24 mg
☐ ~~o~~Other, please explain.

_____

_____

2. What are your limitations on the allowable length of this treatment?

☐ 6 months
☐ 12 months

☐ ~~n~~No limit
☐ ~~o~~Other, please explain.

_____

3. Do you require that the maximum mg per day allowable be reduced after a set period of time?

☐ Yes ☐ No

a) If "Yes," what is your reduced (maintenance) dosage?

☐ 8mg
☐ 12mg
☐ 16mg
☐ ~~o~~Other, please explain.

_____
_____

b) If "Yes," ~~W~~w**hat are your limitations on the allowable length of** the reduced dosage **treatment?**

☐ 6 months
☐ 12 months
☐ ~~n~~No limit
☐ ~~o~~Other, please explain.

_____
_____

4. Do you ~~limit the type of dosage form that can be dispensed to only the sublingual film~~ have at least one preferred buprenorphine/naloxone combination product available on your PDL?

☐ Yes ☐ No

5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug?

☐ Yes ☐ No

If "Yes," can the POS pharmacist override the edit?

☐ Yes ☐ No

G. ~~PSYCHOTROPIC DRUGS~~ ANTIPSYCHOTICS /STIMULANTS

ANTIPSYCHOTICS

1. Do you have a documented program in place to either ~~-~~manage~~/~~ or monitor the appropriate use of ~~psychotropic~~antipsychotic drugs in children?

☐ Yes ☐ No

If "Yes," do you either manage/ or monitor:

☐ oOnly children in foster care
☐ aAll children
☐ oOther, please explain.

_____
_____

If "Yes," do you have edits in place to monitor :

☐ Child's Age ☐ Dosage ☐ Polypharmacy

Please briefly explain the specifics of your antipsychotic monitoring program(s).

_____
_____

If you do not have an antipsychotic monitoring program "No," do you plan on implementing a program in the future?

☐ Yes ☐ No

If "No," please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

_____
_____

STIMULANTS

2. Do you have any documented restrictions or special program in place to monitor/, manage or control the use of stimulants?

☐ Yes ☐ No

If "Yes," is your program limited to:

☐ Cchildren
☐ Aadults
☐ Bboth

Please briefly explain your program.

_____
_____

IX. INNOVATIVE PRACTICES

Have you developed any innovative practices during the past year which you have included in **Attachment 6 - Innovative Practices**? (e.g. Hepatitis C~~CV~~, Cystic Fibrosis, MEDD, Value Based Purchasing)

☐ Yes ☐ No

X. E-PRESCRIBING

~~1. Has your state implemented e-prescribing?~~

~~☐ Yes ☐ No~~

~~If "Yes," please respond to Questions 2 and 3 below. If "No," are you planning to develop this capability?~~

~~3~~1. Does your ~~(~~MMIS or pharmacy vendor~~)~~ have a portal to ~~the capability to~~ electronically provide~~, upon inquiry~~, patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing, upon inquiry?

☐ Yes ☐ No

a) If "Yes," do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

☐ Yes ☐ No

b) If "Yes," please explain the evaluation methodology in **Attachment 7 – E-Prescribing Activity Summary**.

c) If the answer to (number 1) above is "No," are you planning to develop this capability?

☐ Yes ☐ No

2. Does your system use the NCPDP Origin Code that indicates the prescription source?

☐ Yes ☐ No

XI. MANAGED CARE ORGANIZATIONS (MCOs)

1. Does your state have MCO~~'~~s?

☐ Yes ☐ No

If "No," please skip the rest of this section.

~~1~~2. Is your pharmacy program included in the capitation rate (carved-in)?

☐ Yes ☐ No ☐ Partial

If "partial" please specify the drug-categories that are carved out.

_____

_____

~~2~~3. Does the state set requirements for the MCO's pharmacy benefit? (e.g. same PDL, same ProDUR/Retro DUR)

☐ Yes ☐ No

If "Yes," please check all requirements that apply below:

☐ Formulary Reviews ☐ same PDL ☐ same ProDUR ☐ same RetroDUR

If "Yes," please briefly explain your policy.

_____

If "No," do you plan to set standards in the future?

☐ Yes ☐ No

~~4~~3. Does the state require the MCOs to ~~monitor or~~ report their DUR activities?

☐ Yes ☐ No

If "Yes,"~~,~~ please explain your review process.

_____

_____

_____

If "No," do you plan to develop a program to ~~monitor or~~ have ~~report~~ MCO~~(~~s~~)~~ report their DUR activities in the future?

☐ Yes ☐ No

If "No," please explain.

5. Does all of the Medicaid MCOs in your state have a targeted intervention program (i.e. CMC/ Lock In) for the misuse or abuse of controlled substances?

☐ Yes ☐ No

If "No," please explain.

XIII. EXECUTIVE SUMMARY - Attachment 8 – Executive Summary

MEDICAID DRUG UTILIZATION REVIEW ANNUAL REPORT

INSTRUCTIONS: Nomenclature Format for Attachments

States: Please use this standardized format for naming attachments.

ATT#-FFY- State Abbrev-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their 2 letter state code) Attachments:

ATT1-201_-AZ-POCCR (Pharmacy Oral Counseling Compliance Report)

ATT2-201_-AZ-REOS (RetroDUR Educational Outreach Summary)

ATT3-201_-AZ-SDBA (Summary of DUR BD Activities)

ATT4-201_-AZ-GDSP (Generic Drug Substitution Policies)

ATT5-201_-AZ-CSCAM (Cost Savings/Cost Avoidance Methodology)

ATT6-201_-AZ-IPN (Innovative Practices Narrative)

ATT7-201_-AZ-EAS (E-Prescribing Activity Summary)

ATT8-201_-AZ-ES (Executive Summary)

I. EXPLANATION FOR ATTACHMENTS AND TABLES

ATTACHMENT 1 – PHARMACY ORAL COUNSELING COMPLIANCE REPORT

This attachment reports the monitoring of pharmacy compliance with **all prospective DUR** requirements performed by the State Medicaid Agency, the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid Agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the Omnibus Budget Reduction Act (OBRA) of 1990 prospective DUR requirement. This report details state efforts to monitor pharmacy compliance with the oral counseling requirement. This attachment should describe in detail the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.

ATTACHMENT 2 – RETROSPECTIVE EDUCATIONAL OUTREACH SUMMARY

This is a year-end summary report on RetroDUR screening and educational interventions. The year-end summary report should be limited to the **TOP 10** problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included.

ATTACHMENT 3 – SUMMARY OF DUR BOARD ACTIVITIES

This summary should be a brief descriptive report on DUR Board activities during the fiscal year reported. This summary should:

- Indicate the number of DUR Board meetings held.
- List additions/deletions to DUR Board approved criteria.
    a) For prospective DUR, list problem type/drug combinations added or deleted.
    b) For retrospective DUR, list therapeutic categories added or deleted.
- Describe Board policies that establish whether and how results of prospective

DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens.

- Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring).

ATTACHMENT 4 – GENER IC DRUG SUBSTITUTION POLIC IES

Please report any factors that could affect your generic utilization percentage and include any relevant documentation.

ATTACHMENT 5 – COST SAVINGS/COST AVOIDANCE METHODOLOGY

Include copy of program evaluations/cost savings estimates prepared by state or contractor noting methodology used.

ATTACHMENT 6 – INNOVATIVE PRACTIC ES

Please describe in detailed narrative form any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs (e.g., disease management, academic detailing, automated prior authorizations, continuing education programs).

ATTACHMENT 7 – E-PRESCRIBING ACTIV ITY SUMMARY

Please describe all development and implementation plans/accomplishments in the area of e- prescribing. Include any evaluation of the effectiveness of this technology (e.g., number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).

ATTACHMENT 8 – EXECUTIVE SUMMARY

TABLE 1 – TOP ~~10~~DRUG CLAIMS DATA REVIEWED BY THE DUR BOARD ~~[add new table name] PROSPECTIVE DUR CRITERIA REVIEWED BY DUR BOARD~~

~~Indicate by problem type those criteria with the most significant severity levels that were reviewed in-depth by DUR Board. For each problem type below in the first column list the drugs/ drug category/ disease combinations for which DUR Board conducted in-depth reviews.~~

~~PROBLEM TYPE KEY: INAPPROPRIATE - IA; THERAPEUTIC - TC; DRUG DRUG - D/D; DRUG ALLERGY - D/A; DRUG DISEASE – D/D;~~

~~Table1~~	~~AHFS T C (Level 2)~~	~~AHFS T C (Level 4)~~	~~AHFS T C (Level 6)~~	~~AHFS T C (Level 8)~~	~~Drug Name~~	~~Disease~~	~~Criteria Implemented~~
~~IA DOSE1~~							
~~IA DOSE2~~							
~~IA DOSE3~~							
~~TC DUPLICAT ION1~~							
~~TC DUPLICAT ION2~~							
~~TC DUPLICAT ION3~~							
~~D/A INT ERACT ION1~~							
~~D/A INT ERACT ION2~~							
~~D/A INT ERACT ION3~~							
~~IA DURAT ION1~~							
~~IA DURAT ION2~~							
~~IA DURAT ION3~~							
~~D/D INT ERACT IONS1~~							
~~D/D INT ERACT IONS2~~							
~~D/D INT ERACT IONS3~~							
~~D/Dis CONT RAINDICAT ION1~~							
~~D/Dis CONT RAINDICAT ION2~~							
~~D/Dis CONT RAINDICAT ION3~~							
~~OT HER (specify)1~~							
~~OT HER (specify)2~~							
~~OT HER (specify)3~~							
~~OT HER (specify)4~~							
~~OT HER (specify)5~~							
~~OT HER (specify)6~~							
~~OT HER (specify)7~~							
~~OT HER (specify)8~~							

~~OT HER (specify)9~~							

List the requested data in each category in the chart below.
Column 1- Top 10 Prior Authorization (PA) Requests by Drug Name
Column 2- Top 10 PA Requests by Drug Class
Column 3- Top 5 Claim Denial Reasons other than eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, Age Edits)
Column 4- Top 10 Drug Names by Amount Paid
Column 5- From Data in column 4, Determine the Percentage of Total Drug Spend
Column 6- Top 10 Drug Names by Claim Count
Column 7- From Data in Column 6, Determine the Percentage of Total Claims

Top 10 PA Requests By Drug Name	Top 10 PA Requests By Drug Class	Top 5 Claim Denial Reasons (i.e. QL, Early Refill, PA, Duplication)	Top 10 Drug Names by Amount Paid	% of Total Spent for Drugs by Amount Paid	Top 10 Drug Names by Claim Count	Drugs By Claim Count % of Total Claims
		XXXXXXXXXX				
		XXXXXXXXXX				
		XXXXXXXXXX				
		XXXXXXXXXX				
		XXXXXXXXXX				

TABLE 2 – GENER IC UTILIZAT ION DATA

Please provide the following utilization data for this DUR reporting period for all covered outpatient drugs paid. Exclude Third Party Liability. (COMPLETE TABLE 2)

Computation Instructions:

KEY:

Single-Source (S) - Drugs having an FDA New Drug Application (NDA), and there are no generic alternatives available on the market.

Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA), and there exists generic alternatives on the market.

Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity.

1. Generic Utilization Percentage: To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula:

N ÷ (S + N + I) × 100 = Generic Utilization Percentage

2. Generic Expenditures Percentage of Total Drug Expenditures: To determine the generic expenditure percentage (rounded to the nearest $1000) for all covered outpatient drugs for this reporting period use the following formula:

$N ÷ ($S + $N + $I) × 100 = Generic Expenditure Percentage

TABLE 2: GENERIC DRUG UTILIZATION

Single-Source (S) Drugs		Non-Innovator (N) Drugs		Innovator Multi-Source (I) Drugs	
Total Number of Claims	*Total Reimbursement Amount Less Co-Pay*	*Total Number of Claims*	*Total Reimbursement Amount Less Co-Pay*	*Total Number of Claims*	*Total Reimbursement Amount Less Co-Pay*

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I (see Key below). This file will be made available from CMS to facilitate consistent reporting across States with this data request.