ABOUT THE SURVEY

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.

Note: Covered Outpatient Drugs (COD) are referenced throughout this survey and refers to participating labelers in the Medicaid Drug Rebate Program (MDRP).

This report covers the period October 1, 2023 to September 30, 2024 and is due for submission to Centers for Medicare & Medicaid Services (CMS) Central Office by no later than June 30, 2025. Answering the attached questions and returning the re quested materials as attachments to the report will constitute compliance with the above mentioned statutory requirement.

CMS does not edit state responses; therefore, what is submitted by the state will be what is posted on Medicaid.gov. This material is also utilized for composing the annual report to Congress.

If you have any questions regarding the DUR Annual Report, please contact CMS via email at: CMSDUR@cms.hhs.gov.

PRA DISCLOSURE STATEMENT (CMS-R-153)

This mandatory information collection (section 4401 of the Omnibus Budget Reconciliation Act of 1990 and section 1927(g) of the Social Security Act) is necessary to establish patient profiles in pharmacies, identify problems in prescribing and/or dispensing, determine each program's ability to meet minimum standards required for federal financial participation, and ensure quality pharmaceutical care for Medicaid patients. State Medicaid agencies that have prescription drug programs are required to perform prospective and retrospective DUR in order to identify aberrations in prescribing, dispensing and/or patient behavior. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this information collection request is 0938-0659 (Expires: XX/XX/XXXX). Public burden for all of the collection of information requirements under this control number is estimated at 65 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

I have read the information about this survey.

I. DEMOGRAPHIC INFORMATION

State Abbreviation: _____

Medicaid Program Information

Identify state person responsible for DUR Annual Report Preparation.

First Name: _____

Last Name: _____

Email Address: _____

Position Title: _____

1. On a monthly average, how many of your state's Medicaid beneficiaries are enrolled in your state's Medicaid Fee-For-Service (FFS) program that have a pharmacy benefit?

   _____ Beneficiaries

2. On a monthly average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s) that provides drug benefit(s)?

   _____ Beneficiaries

II. PROSPECTIVE DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) vendor.

   - ○ State-Operated
   - ○ Contractor
   - ○ Other

   a. Vendor Name

   _____

   b. Who processes the state's National Council for Prescription Drug Programs (NCPDP) transactions?

      - ○ POS vendor is the fiscal agent (FA)
      - ○ POS vendor is a separate Pharmacy Benefits Manager (PBM)
      - ○ Other, please explain.

        _____

2. Identify your ProDUR table driven criteria source. This would be initial ratings such as drug to drug interactions, dose limits based on age, etc…. Check **all** that apply.

   - ☐ First Databank
   - ☐ Medi-Span
   - ☐ Micromedex
   - ☐ Other, please specify _____

3. 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 "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?

   - ○ Yes
   - ○ Varies by alert type
   - ○ No

   If *"Yes"* or *"Varies by Alert Type,"* check **all** that apply.

   - ☐ Alerts can be overridden ahead of time

- ☐ Alerts can be overridden with standard professional codes
- ☐ Alerts need prior authorization (PA) to be overridden
- ☐ Other, please explain.

_____

_____

_____

4. Does your state receive periodic reports providing individua l pharmacy providers DUR alert override activity in summary and/or in detail?

   - ○ Yes
   - ○ No, please explain.

_____

_____

a. If "*Yes,*" How often does your state receive reports?

   - ☐ Monthly
   - ☐ Quarterly
   - ☐ Annually
   - ☐ Ad hoc (on request)
   - ☐ Other, please explain.

_____

_____

_____

b. If "*Yes,*" does your state follow up with those providers who routinely override with interventions?

   - ○ Yes

   If "*Yes,*" by what method does your state follow up?

   - ☐ Contact Pharmacy
   - ☐ Refer to Program Integrity for Review
   - ☐ Other, please explain.

_____

_____

_____

- O No, please explain.

_____

_____

_____

5. **Early Refill**

a. At what percent threshold does your state set your system to edit?

i. Non-controlled drugs:

_____ %

ii. Schedule II controlled drugs:

_____ %

iii. Schedule III through V controlled drugs:

_____ %

b. **For non-controlled drugs:**

When an early refill message occurs, does your state require a PA?

- O Yes
- O No
- O Dependent on medication or situation

If *"Yes"* or *"Dependent on medication or situation,"* who obtains authorization?

- O Pharmacist
- O Prescriber
- O Pharmacist or Prescriber

If *"No,"* can the pharmacist override at the POS?

- O Yes
- O No

c. **For controlled drugs:**

When an early refill message occurs, does your state require a PA?

- ○ Yes
- ○ No

If *"Yes,"* who obtains authorization?

- ○ Pharmacist
- ○ Prescriber
- ○ Pharmacist or Prescriber

If *"No,"* can the pharmacist override at the POS?

- ○ Yes
- ○ No

6. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your state's policy allow the pharmacist to override for situations such as (check all that apply):

- ○ Lost/stolen RX
- ○ Vacation
- ○ Overrides are only allowed by a pharmacist through a PA
- ○ Other, please explain.

_____

_____

7. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?

- ○ Yes
- ○ No

If *"Yes,"* please explain your edit.

_____

_____

If *"No,"* does your state plan to implement this edit?

- ○ Yes
- ○ No

8. Does the state Medicaid program have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?

   - ○ Yes
   - ○ No

9. Does your system have a diagnosis edit that can be utilized when processing a prescription?

   ¡ Yes, please explain.

   _____
   _____
   _____

   ¡ No

10. Does your Medicaid program have a documented process (i.e. PA) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any rebate participating manufacturer covered outpatient drug when medically necessary?

    ○ Yes

    Please check **all** that apply.

    - ☐ Automatic PA based on diagnosis codes or systematic review
    - ☐ Trial and failure of first or second-line therapies to support Preferred Drug List
    - ☐ Pharmacist or technician reviews
    - ☐ Direct involvement with Pharmacy and/or Medical Director
    - ☐ Other, please explain.

      _____

      _____

O No, please explain why not.

a. Does your program provide for the dispensing of at least a 72-hour supply of a covered outpatient drug (COD) in an emergency situation? Please check **all** that apply.

☐ Real-time automated process

☐ Retrospective PA

☐ Other process, please explain.

11. Please list the requested data in each category in *Table 1 – Top Drug Claims Data Reviewed by the DUR Board* below.

Column 1 – Top 10 PA Requests by Drug Name, report at generic ingredient level Column 2 – Top 10 PA Requests by Drug Class

Column 3 – Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD), and Age Edits (AE))

Column 4 – Top 10 Drug Names by Amount Paid, report at generic ingredient level Column 5 – From Data in column 4, determine the Percentage of Total Drug Spend Column 6 – Top 10 Drug Names by Claim Count, report at generic ingredient level Column 7 – From Data in Column 6, determine the Percentage of Total Claims

Table 1: Top Drug Claims Data Reviewed by the DUR Board

NOTE: If an entry is not included in the drop-down box list, please select ‘other’ at end of the list and enter a free form response in the box below.

Column 1 **Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level**	Column 2 **Top 10 Prior Authorization (PA) Requests by Drug Class**	Column 3 **Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD) and Age Edits (AE))**	Column 4 **Top 10 Drug Names by Amount Paid, report at generic ingredient level**	Column 5 **% of Total Spent for Drugs by Amount Paid (From data in Column 4, Determine the % of total drug spend)**	Column 6 **Top 10 Drug Names by Claim Count, report at generic ingredient level**	Column 7 **Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)**
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%

12. Section 1927(g)(A) of the 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.

- ☐ Medicaid Program
- ☐ State Board of Pharmacy
- ☐ Other, please explain.

_____

_____

_____

a. Please explain the steps taken by the state agency to monitor compliance by pharmacies with the prospective DUR counseling requirements contained in federal and state laws and regulations.

_____

_____

_____

III. RETROSPECTIVE DUR (RetroDUR)

1. Indicate the type of vendor that performed your RetroDUR activities during the time period covered by this report.

   - ○ Vendor
   - ○ Academic Institution
   - ○ Other Institution

   a. Identify, by name, your RetroDUR vendor.

   _____

   b. Is the RetroDUR vendor the Medicaid Management Information System (MMIS) fiscal agent?

      - ○ Yes
      - ○ No

   c. Is the RetroDUR vendor the developer/supplier of your retrospective DUR criteria?

      - ○ Yes
      - ○ No

   Please explain *"Yes"* or *"No"* response.

   _____

   _____

   _____

   d. Does your state customize your RetroDUR vendor criteria?

      - ○ Yes
      - ○ No
      - ○ Ad hoc based on state-specific needs

2. How often does your state perform retrospective practitioner-based education?

   - ○ Monthly
   - ○ Bi-monthly

- ○ Quarterly
- ○ Other, please specify.

_____

_____

_____

a. How often does your state perform retrospective reviews that involve communication of client specific information to healthcare practitioners (through messaging, fax, or mail)? Check **all** that apply.

- ☐ Monthly
- ☐ Bi-Monthly
- ☐ Quarterly
- ☐ Other, please specify.

_____

_____

_____

b. What is the preferred mode of communication when performing RetroDUR initiatives? Check **all** that apply.

- ☐ Mailed letters
- ☐ Provider phone calls
- ☐ Near real-time fax
- ☐ Near real-time messaging
- ☐ Other new technologies such as apps or Quick Response (QR) codes
- ☐ Focused workshops, case management, or WebEx training
- ☐ Newsletters or other non-direct provider communications
- ☐ Other, please specify _____

3. **Summary 1 – RetroDUR Educational Outreach**

RetroDUR Educational Outreach Summary should be a year-end report on retrospective screening and educational interventions. The summary should be limited to the most prominent problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed below.

_____

IV. DUR BOARD ACTIVITY

1. Does your state have an approved Medication Therapy Management (MTM) Program?

   ○ Yes
   ○ No

2. Does your state have a separate advisory board for your PDL?

   ○ Yes
   ○ No

3. **Summary 2 – DUR Board Activities**

DUR Board Activities Summary should include a brief descriptive on DUR 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:
  - For ProDUR, list problem type/drug combinations added or deleted.
  - For RetroDUR, list therapeutic categories added or deleted.
- Describe Board policies that establish whether and how results of ProDUR screening are used to adjust RetroDUR screens.
- Describe policies that establish whether and how results of RetroDUR screening are used to adjust ProDUR screens.
- Describe DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.).
- Describe policies adopted to determine the mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring).

V. PHYSICIAN ADMINISTERED DRUGS (PAD)

The Deficit Reduction Act required collection of national drug code (NDC) numbers for covered outpatient physician administered drugs. These drugs are paid through the medical benefit. Has your MMIS been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

   - ○ Yes
   - ○ No

   If *"No,"* does your state have a plan to include this information in your DUR criteria in the future?

   - ○ Yes
   - ○ No

2. RetroDUR?

   - ○ Yes
   - ○ No

   If *"No,"* does your state have a plan to include this information in your DUR criteria in the future?

   - ○ Yes
   - ○ No

VI. GENERIC POLICY AND UTILIZATION DATA

1. **Summary 3 – Generic Drug Substitution Policies**

   Generic Drug Substitution Policies should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, preferred drug list (PDL) policies, educational initiatives, technology or promotional factors, or other state specific factors that affects your generic utilization rate.

   _____

   _____

   _____

   _____

   _____

   _____

   _____

2. In addition to the requirement that the prescriber write in his 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.

   ☐ Require that a MedWatch Form be submitted

   ☐ Require the medical reason(s) for override accompany the prescription(s)

   ☐ Prior authorization (PA) is required

   ☐ Other, please explain.

   _____

   _____

   _____

Table 2: Generic Drug Utilization Data

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 generic alternatives exist 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:

   $$N \div (S + N + I) \times 100 = \text{Generic Utilization Percentage}$$

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:

   $$\$N \div (\$S + \$N + \$I) \times 100 = \text{Generic Expenditure Percentage}$$

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, which can be found at Medicaid.gov (Click on the link "*National Drug Code and Drug Category file* [ZIP]," then open the Medicaid Drug Product File 4th Qtr. Excel file).

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

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

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

   Number of Generic Claims: _____

   Total Number of Claims: _____

   Generic Utilization Percentage: _____%

4. Does your Medicaid program have a brand over generic program when the brand product nets a lower cost.

   ○ Yes

   ○ No

5. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period using the computation instructions in **Table 2: Generic Drug Utilization Data**.

   Generic Dollars: $_____

   Total Dollars: $_____

   Generic Expenditure Percentage: _____%

6. Does your state have any policies related to biosimilars? Please explain.

   _____

   _____

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

   If *"Yes,"* identify, by name and type, the institution that conducted the program evaluation.

   Institution Type

   ○ Vendor
   ○ Academic Institution
   ○ Other Institution

   Institution Name

   _____

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

	Cost in Dollars
ProDUR Total Estimated Avoided Costs	
RetroDUR Total Estimated Avoided Costs	
Other Cost Avoidance	
Grand Total Estimate d Avoided Costs	

3. The Estimated Percent Impact was generated by dividing the Grand Total Estimated Avoided Costs from Question 2 above by the Total Dollar Amount provided in Section VI, Question 5, then multiplying this value by 100.

   Estimated Percent Impact: _____%

4. Does your program allow pharmacists to order either prescription or OTC medications through:
   - ○ Standing orders
   - ○ Collaborative practice agreements
   - ○ State Board authorized prescriptive authority
   - ○ Other predetermined protocols, please explain:

     _____
     _____
     _____

   What categories of drugs are dispensed through these types of agreements?

   _____
   _____
   _____

5. **Summary 4 – Cost Savings/Cost Avoidance Methodology**
   Cost Savings/Cost Avoidance Methodology Summary should include program evaluations/cost savings estimates prepared by the state or contractor. Please provide detailed summary below.

   _____

   _____

   _____

VIII. FRAUD WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

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

   ○ Yes
   ○ No, please explain why not.

   _____
   _____
   _____

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

   ☐ Deny claims
   ☐ Require prior authorization (PA)
   ☐ Refer to Lock-In Program
   ☐ Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
   ☐ Refer to Office of Inspector General (OIG)
   ☐ Other, please explain.

   _____
   _____
   _____

2. Does your state have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?

   ○ Yes
   ○ No

   If *"Yes,"* please continue.

a. 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
- ☐ Days' supply of CS
- ☐ Exclusivity of short acting opioids
- ☐ Multiple emergency room (ER) visits
- ☐ Prescription drug monitoring program (PDMP) data
- ☐ Other, please explain.

_____

_____

_____

b. Does your state have the capability to restrict the beneficiary to:

i) Prescriber only

- ○ Yes
- ○ No

ii) Pharmacy only

- ○ Yes
- ○ No

iii) Prescriber and pharmacy

- ○ Yes
- ○ No

c. What is the usual Lock-In time period?

- ○ 12 months
- ○ 18 months
- ○ 24 months
- ○ As determined by the state on a case-by-case basis
- ○ Lock-in time period is based on number of incidences/occurrences

- ○ Other, please explain.

_____

_____

_____

d. On average, what percentage of the FFS population is in Lock-In status annually?

_____ %

e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review or N/A if your state does not estimate savings.

- ○ $_____
- ○ N/A

3. Does your state have a documented process in place that identifies possible FWA of controlled drugs by **pre scribers**?

- ○ Yes

What actions does this process initiate? Check **all** that apply:

- ☐ Deny claims written by this prescriber
- ☐ Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
- ☐ Refer to the appropriate Medical Board
- ☐ Other, please explain.

_____

_____

_____

- ○ No, please explain why not.

_____

_____

_____

4. Does your state have a documented process in place that identifies potential FWA of controlled drugs by **pharmacy providers**?

   ○ Yes

   What actions does this process initiate? Check **all** that apply:

   ☐ Deny claim
   ☐ Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
   ☐ Refer to Board of Pharmacy
   ☐ Other, please explain.

   _____

   _____

   _____

   ○ No, please explain why not.

   _____

   _____

   _____

5. Does your state have a documented process in place that identifies and/or prevents potential FWA of non-controlled drugs by **beneficiaries, prescribers, and pharmacy providers**?

   ○ Yes, please explain your program for FWA of non-controlled substances.

   _____

   _____

   _____

   ○ No, please explain why not.

   _____

   _____

   _____

6. Briefly explain the states' objectives and scope of responsibility between DUR and SUR functions as they relate to FWA. Additionally, explain how the state maintains separation between fraud and abuse and educational activities. (Character limit 1000)

_____
_____
_____

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Does your Medicaid program have the ability to query the state's PDMP database?

¡ Yes, for all data files

¡ Yes, for selective beneficiary and provider searches

¡ No, please explain.

_____
_____
_____

If *"Yes,"* please continue.

a. Please check all applicable ways the state accesses the PDMP database.

☐ Receive PDMP data
☐ Direct access to the database

i. If *"Receive PDMP data,"* please indicate how often. Check all that apply.

☐ Daily
☐ Weekly
☐ Monthly
☐ Other _____

ii. If *"Direct access to the database,"* please specify. Check all that apply.

☐ Can query by client
☐ Can query by prescriber
☐ Can query by dispensing entity

b. Please explain how the state applies this information to control FWA of controlled substances.

_____
_____
_____

c. Does your state also have access to contiguous states' PDMP information?

- O Yes
- O No

2. In the state's PDMP system, which of the following beneficiary information is available to prescribers as close to real-time as possible? Check **all** that apply.

- ¨ PDMP drug history
- ¨ The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period
- ¨ The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills
- ¨ Other, please explain.

_____
_____
_____

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

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

_____
_____
_____

- ¡ No

3. How have you communicated to prescribers who are covered providers that they are required to check the PDMP before prescribing controlled substances to beneficiaries who are covered individuals? Check all that apply.

- ☐ Provider bulletin
- ☐ Program website
- ☐ Provider blast fax
- ☐ DUR letter
- ☐ Public notice
- ☐ Provider manual
- ☐ RetroDUR communication
- ☐ Other, please explain.

_____
_____

¡ No, please explain.

_____
_____
_____

a. Has the state specified protocols for prescribers checking the PDMP?

O Yes, please explain.

_____
_____
_____

O No

b. Do providers receive protocols for responses to information from the PDMP that is contradictory to information that the practitioner expects to receive (example: when a provider prescribing pain management medication finds medications for opioid use disorder (OUD) during a PDMP check, when client denies opioid use disorder)?

O Yes

O No

c. If a provider is not able to conduct PDMP check, does your state require the prescriber to document a good faith effort, including the reasons why the provider was not able to conduct the check?

O Yes

O No, please explain why not.

_____
_____
_____

If *"Yes,"* does your state require the provider to submit, upon request, documentation to the state?

O Yes

O No, please explain.

_____

_____
_____

4. Please specify below the following information for the 12-month reporting period for this survey.

   a. Does your state or professional board require pharmacists to check the PDMP prior to dispensing a controlled substance to a covered individual?

   ○ Yes

   ○ No, please explain.

   _____
   _____
   _____

   If *"Yes,"* are there protocols involved for pharmacists in checking the PDMP?

   ○ Yes, please explain.

   _____
   _____
   _____

   ○ No

   b. The percentage of covered providers (as determined pursuant to a process established by the state) who checked the prescription drug history of a beneficiary through a PDMP before prescribing a controlled substance to such an individual:

   _____ %

   i. How was the above calculation obtained?

   ○ A provider survey
   ○ A provider attestation
   ○ A PDMP vendor report
   ○ Raw PDMP data using the median
   ○ Other, please explain.

   _____

   _____

c. For sub questions d., e., f., g. and the Tables 3, 4, 5 and 6 below, please specify the type of data utilized in determining the calculations.

- ○ Raw PDMP data
- ○ MMIS claims
- ○ A PDMP vendor report
- ○ Multiple data sources, please explain which source is used for each question below.
- ○ Other, please explain.

_____

_____

i. Do these calculations include cash payments?

- ○ Yes
- ○ No

d. Total morphine milligram equivalents (MME) dispensed in 12 month reporting period:
_____ MME

e. Total MME dispensed per covered individual:
_____ MME

f. Total MME dispensed per covered individual who received an opioid prescription:
_____ MME

g. Average daily MME dispensed per opioid prescription:

_____ MME

h. Please complete Tables 3, 4, 5 and 6 below. Specify the controlled substances prescribed based on prescriptions dispensed (by generic ingredient(s)) and within each population during this 12-month FFY reporting period.

Table 3: Opioid Controlled Substance s by Population

Population	Column 1 Total Number of Beneficiaries Within Each Age Group	Column 2 Total Number of Unique Beneficiaries Within Each Age Group Receiving an Opioid Controlled Substance in the 12 Month Reporting Period	Column 3 Percentage of Unique Beneficiaries Within Each Age Group Receiving an Opioid Controlled Substance in the 12 Month Reporting Period	Column 4 Top 3 Opioid Controlled Substances Received Within Each Age Group (Generic Ingredient) in the 12 Month Reporting Period	Column 5 Number of Unique Beneficiaries Within Each Age Group Receiving the Opioid Controlled Substance (Specified in Column 4) in the 12 Month Reporting Period	Column 6 Percentage of Unique Beneficiaries Within Each Age Group Receiving the Top 3 Opioid Controlled Substances (Specified in Column 4) in the 12 Month Reporting Period
0-18 yrs.						
19-29 yrs.						
30-39 yrs.						
40-49 yrs.						
50-59 yrs.						
60-69 yrs.						
70-79 yrs.						
80+ yrs.						
Individuals with Disabilities Utilizing State Eligibility Categories						

Table 4: Top Se dative /Benzodiazepine s Controlled Substance s by Population
When listing the controlled substances in different drug categories, for the purpose of Table 4 below, please consider long and short acting benzodiazepines to be in the same category.

Population	Column 1 Total Number of Beneficiaries Within Each Age Group	Column 2 Total Number of Unique Beneficiaries Within Each Age Group Receiving a Sedative/Benzodiazepine in the 12 Month Reporting Period	Column 3 Percentage of Unique Beneficiaries Within Each Age Group Receiving a Sedative/Benzodiazepine in the 12 Month Reporting Period	Column 4 Top 3 Sedative/Benzodiazepine Received Within Each Age Group (Generic Ingredient) in the 12 Month Reporting Period	Column 5 Number of Unique Beneficiaries Within Each Age Group Receiving the Sedative/Benzodiazepine (Specified in Column 4) in the 12 Month Reporting Period	Column 6 Percentage of Unique Beneficiaries Within Each Age Group Receiving the Top 3 Sedative/Benzodiazepine (Specified in Column 4) in the 12 Month Reporting Period
0-18 yrs.						
19-29 yrs.						
30-39 yrs.						
40-49 yrs.						
50-59 yrs.						
60-69 yrs.						
70-79 yrs.						
80+ yrs.						
Individuals with Disabilities Utilizing State Eligibility Categories						

Table 5: Top Stimulant/ADHD Controlled Substance s by Population

When listing the controlled substances in different drug categories, please consider long and short acting ADHD medications to be in the same category.

Population	Column 1 Total Number of Beneficiaries Within Each Age Group	Column 2 Total Number of Unique Beneficiaries Within Each Age Group Receiving a Stimulant/ADHD Controlled Substance in the 12 Month Reporting Period	Column 3 Percentage of Unique Beneficiaries Within Each Age Group Receiving a Stimulant/ADHD Controlled Substance in the 12 Month Reporting Period	Column 4 Top 3 Stimulant/ADHD Controlled Substances Received Within Each Age Group (Generic Ingredient) in the 12 Month Reporting Period	Column 5 Number of Unique Beneficiaries Within Each Age Group Receiving the Stimulant/ADHD Controlled Substance (Specified in Column 4) in the 12 Month Reporting Period	Column 6 Percentage of Unique Beneficiaries Within Each Age Group Receiving the Top 3 Stimulant/ADHD Controlled Substance (Specified in Column 4) in the 12 Month Reporting Period
0-18 yrs.						
19-29 yrs.						
30-39 yrs.						
40-49 yrs.						
50-59 yrs.						
60-69 yrs.						
70-79 yrs.						
80+ yrs.						
Individuals with Disabilities Utilizing State Eligibility Categories						

Table 6: Populations on 2 or more Controlled Substance s in Different Drug Categories

When listing the controlled substances in different drug categories, for the purpose of Table 6 below, please consider long and short acting opioids to be in the same category. Please follow this approach for long and short acting ADHD medications and benzodiazepines in this table as well. Please note, Column 2 and Column 4 are requesting an average monthly value based on the 12 month reporting period.

Population	Column 1 Total Number of Beneficiaries within Each Age Group	Column 2 Number of Unique Beneficiaries in Each Age Group/Month Receiving 2 or more Controlled Substances in Different Drug Categories per Month Averaged for the 12 Month Reporting Period	Column 3 Percentage of Age Group Receiving 2 or More Controlled Substances per Month Averaged for the 12 Month Reporting Period	Column 4 Number of Unique Beneficiaries in Each Age Group Receiving 3 or more Controlled Substances in Different Drug Categories per Month Averaged for the 12 Month Reporting Period	Column 5 Percentage of Age Group Receiving 3 or more Controlled Substances per Month Averaged for the 12 Month Reporting Period
0-18 yrs.					
19-29 yrs.					
30-39 yrs.					
40-49 yrs.					
50-59 yrs.					
60-69 yrs.					
70-79 yrs.					
80+ yrs.					
Individuals with Disabilities Utilizing State Eligibility Categories					

i. If there is additional information you want to provide about the calculations and/or the Tables above for the 12-month reporting period, please explain below or **specify N/A if not applicable .**

_____

_____

_____

j. Has your state exempted certain individuals, (see the definition of Covered Individuals under section 1944(h)(2) of the Act, as added by Section 5042 of the SUPPORT Act), from the associated reporting requirements? Check all that apply.

- ☐ Individuals receiving hospice
- ☐ Individuals receiving palliative care
- ☐ Individuals receiving cancer treatments
- ☐ Residents of long-term care facilities or other facility specified in section 1944(g)(2)(B)
- ☐ Babies with neonatal abstinence syndrome (also called NAS)
- ☐ Other population 1, please explain_____
- ☐ Other population 2, please explain_____
- ☐ Other population 3, please explain_____

i. If any of the information requested is not being reported above, please explain below or **specify N/A if not applicable .**

_____

_____

_____

5. Have you had any changes to your state's PDMP during this reporting period that have improved the Medicaid program's ability to access PDMP data?

- ○ Yes, please explain.

_____

_____

_____

- ○ No

6. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?

○ Yes

○ No

If "*Yes,*" please summarize the breach, the number of individua ls impacted, a description of the steps the state has taken to address each such breach, and if law enforcement or the affected individua ls were notified of the breach.

C. OPIOIDS

1. Does your state currently have a POS edit in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients?

   - ○ Yes, for **all** opioids
   - ○ Yes, for some opioids
   - ○ No, please explain why not.

   _____

   _____

   _____

   If the answer to question 1 is *"Yes, for all opioids"* or *"Yes, for some opioids,"* please continue. If the answer to question 1 is "*No*," please skip to 1b.

   a. What is the maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?

      _____ # of days

   b. Does your state have POS edits in place to limit days' supply of subsequent opioid prescriptions? If yes, please indicate your days supply limit.

      - ○ 24-day supply
      - ○ 30-day supply
      - ○ 34-day supply
      - ○ 90-day supply
      - ○ Other_____
      - ○ No, please explain.

      _____

      _____

      _____

2. Does your state have POS edits in place to limit the quantity dispensed of opioids?

¡ Yes

¡ No, please explain why not.

_____
_____
_____

If "*Yes,*" please continue.

a. Does your state have POS edits in place to limit the quantity dispensed of short- acting (SA) opioids?

O Yes

O No, please explain.

_____

_____

_____

O Other, please explain.

_____

_____

_____

b. Does your state currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?

O Yes

O No, please explain.

_____

_____

_____

O Other, please explain.

3. Does your state have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?

- ○ Yes
- ○ No

If "*Yes,*" check **all** that apply.

- ☐ Pharmacist override
- ☐ Deny claim and require PA
- ☐ Intervention letters
- ☐ MME daily dose program
- ☐ Step therapy or clinical criteria
- ☐ Requirement that patient has a pain management contract or Patient-Provider agreement
- ☐ Requirement that prescriber has an opioid treatment plan for patients
- ☐ Require documentation of urine drug screening results
- ☐ Require diagnosis
- ☐ Require PDMP checks
- ☐ Workgroups to address opioids
- ☐ Other, please specify.

Please provide details on these opioid prescribing controls in place.

If "*No*," 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 opioids.

4. Does your state have POS edits to monitor duplicate therapy of opioid prescriptions? This excludes regimens that include a single extended-release product and a breakthrough short acting agent?

   - ○ Yes
   - ○ No, please explain why not.

5. Does your state have POS edits to monitor early refills of opioid prescriptions dispensed?

   - ○ Yes, POS edits
   - ○ Yes, both POS edits and automated retrospective claims review process
   - ○ No, please explain why not.

6. Does your state have comprehensive automated retrospective claim reviews to monitor opioid prescriptions exceeding these state limitations (early refills, duplicate fills, quantity limits and days' supply)?

   - ○ Yes, please explain in detail scope, nature, and frequency of these retrospective reviews.

   - ○ No, please explain why not.

7. Does your state currently have automated retrospective claim reviews to monitor opioids and benzodiazepines being used concurrently?

   ○ Yes, automated retrospective claim reviews
   ○ Yes, both POS edits and automated retrospective claim reviews

   Please explain above response and detail the scope and nature of these reviews and edits. Additionally, please explain any potential titration processes utilized for those patients chronically on benzodiazepines and how the state justifies pain medications, i.e. Oxycodone/APAP, for breakthrough pain without jeopardizing patient care (i.e. quantity limits/practitioner education titration programs).

   _____

   _____

   _____

   ○ No, please explain why not.

   _____

   _____

   _____

8. Does your state currently have automated retrospective claim reviews to monitor opioids and sedatives being used concurrently?

   ○ Yes, automated retrospective claim reviews
   ○ Yes, both POS edits and automated retrospective claim reviews
   ○ No, please explain why not.

   _____

   _____

   _____

9. Does your state currently have automated retrospective claim reviews to monitor opioids and antipsychotics being used concurrently?

   ○ Yes, automated retrospective claim reviews
   ○ Yes, both POS edits and automated retrospective claim reviews
   ○ No, please explain why not.

   _____

   _____

10. Does your state have POS safety edits or perform automated retrospective claim reviews and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?

- ○ Yes
- ○ No, please explain why not.

If *"Yes,"* please check **all** that apply.

- ☐ POS edits
- ☐ Automated retrospective claim reviews
- ☐ Provider education

If *Automated retrospective claim reviews and/or "Provider education,"* please indicate how often.

- ○ Monthly
- ○ Quarterly
- ○ Semi-Annually
- ○ Annually
- ○ Ad hoc
- ○ Other, please specify.

If *"No,"* does your state plan on implementing POS edits, automated retrospective claim reviews and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?

- ○ Yes, when does your state plan on implementing?

- ○ No, please explain why not.

_____

_____

_____

11. Does your state Medicaid program develop and provide prescribers with pain management or opioid prescribing guidelines?

- ○ Yes
- ○ No

If *"Yes,"* please check **all** that apply.

- ☐ Your state Medicaid program refers prescribers to the Center for Disease Control (CDC) 2022 Clinical Practice Guideline for Prescribing Opioids for Pain..
- ☐ Other guidelines, please identify.

_____

_____

_____

If *"No,"* please explain why no guidelines are offered.

_____

_____

_____

12. Does your state have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?

- ○ Yes, please explain.

_____

_____

_____

- ○ No, please explain

_____

13. Have there been state specific events (unplanned outages, natural disasters, public health emergencies, etc…) that have had ramifications on edits, reviews or prescribing for this reporting period?

- ○ Yes, please explain.

- ○ No

D. MORPHINE MILLIGRAM EQUIVALENT (MME) DAILY DOSE

1. Have you set recommended maximum MME daily dose measures?

   - ○ Yes
   - ○ No

   If *"Yes,"* please continue.

   a. What is your maximum morphine equivalent daily dose limit in milligrams?

      - ○ Less than 50 MME, please specify: _____mg per day
      - ○ 50 MME
      - ○ 70 MME
      - ○ 80 MME
      - ○ 90 MME
      - ○ 100 MME
      - ○ 120 MME
      - ○ 200 MME
      - ○ Greater than 200 MME, please specify. _____mg per day
      - ○ Other, please specify._____ mg per day
      - ○ More than 1 MME accessed in state

   b. Please explain nature and scope of dose limit (i.e. Who does the edit apply to? Does it apply to new users/chronic users? Does the limit apply to **all** opioids? Are you in the process of tapering patients to achieve this limit?).

      _____

      _____

      _____

   If *"No,"* please explain why not.

   _____

   _____

   _____

2. Does your state have an edit in your POS system that alerts the pharmacy provider

that the MME daily dose prescribed has been exceeded?

- ○ Yes
- ○ No, please explain why not.

_____
_____
_____

If *"Yes,"* does your state require PA if the MME limit is exceeded?

- ○ Yes
- ○ No

3. Does your state have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed?

- ○ Yes
- ○ No, please explain why not.

_____
_____
_____

4. Do you provide information to your prescribers on how to calculate the MME daily dosage or do you provide a calculator developed elsewhere?

- ○ Yes
- ○ No

If *"Yes,"* please continue.

a. Please name the developer of the calculator:

- ○ CDC
- ○ Academic Institution
- ○ Other, please specify.

_____
_____
_____

b. How is the information disseminated? Check **all** that apply.

- ☐ Website
- ☐ Provider notice
- ☐ Educational seminar
- ☐ Other, please explain.

_____

_____

_____

E. OPIOID USE DISORDER (OUD) TREATMENT

1. Does your state have utilization controls (i.e. preferred drug list (PDL), prior authorization (PA), quantity limit (QL)) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?

   ○ Yes, please explain.

   _____

   _____

   _____

   ○ No, please explain.

   _____

   _____

   _____

2. Does your Medicaid program set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

   ○ Yes

   ○ No

   If *"Yes,"* please specify the total mg/day:

   ○ 12 mg

   ○ 16 mg

   ○ 24 mg

   ○ 32 mg

   ○ Other, please explain.

   _____

   _____

   _____

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

- ○ No limit
- ○ 3 months or less
- ○ 6 months
- ○ 12 months
- ○ 24 months
- ○ Other, please explain.

_____

_____

_____

4. Does your state require that the maximum mg per day allowable be reduced after a set period of time?

   - ○ Yes
   - ○ No

   If *"Yes,"* please continue.

   a. What is your reduced (maintenance) dosage?

      - ○ 8 mg
      - ○ 12 mg
      - ○ 16 mg
      - ○ Other, please explain.

      _____

      _____

      _____

   b. What are your limitations on the allowable length of the reduced dosage treatment?

      - ○ No limit
      - ○ 6 months
      - ○ 12 months
      - ○ Other, please explain.

      _____

      _____

5. Does your state have at least one buprenorphine/naloxone combination product available without PA?

   - ○ Yes
   - ○ No

6. Does your state currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?

   - ○ Yes
   - ○ No, please explain why not.

   _____

   _____

   _____

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

   - ○ Yes
   - ○ No

7. Is there at least one formulation of naltrexone for OUD available without PA?

   - ○ Yes
   - ○ No

8. Does your state have at least one opioid reversal agent available without PA?

   - ○ Yes
   - ○ No

9. Does your state monitor and manage appropriate use of opioid reversal agents to persons at risk of overdose?

   - ○ Yes

- ○ No, please explain why not.

_____

_____

_____

10. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid program allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?

- ○ Yes, State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid program under protocol
- ○ Yes, prescribed independently
- ○ No

F. OUTPATIENT TREATMENT PROGRAMS (OTP)

1. Does your state cover OTPs that provide Behavioral Health (BH) and MAT services?

   ○ Yes
   ○ No, please explain why not.

   _____

   _____

   _____

   If *"Yes"*, is a referral needed for OUD treatment through OTPs?

   ○ Yes
   ○ No

   Please explain.

   _____

   _____

   _____

2. Does your state Medicaid program cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?

   ○ Yes
   ○ No, please explain.

   _____

   _____

   _____

3. Does your state Medicaid program cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?

   ○ Yes
   ○ No, please explain.

   _____

   _____

G. PSYCHOTROPIC MEDICATION

ANTIPSYCHOTICS

1. Does your state have a documented program in place to manage and monitor the appropriate use of antipsychotic drugs in children?

   ○ Yes
   ○ No

   If *"Yes,"* please continue.

   a. Does your state manage and monitor:

      ○ Only children in foster care under 18 y.o.
      ○ **All** children including foster care under 18 y.o.
      ○ Other, please explain.

      _____

      _____

      _____

   b. Does your state have edits in place to monitor (check **all** that apply):

      ☐ Child's age
      ☐ Dosage
      ☐ Indication
      ☐ Polypharmacy
      ☐ Other, please explain.

      _____

      _____

      _____

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

      _____

      _____

      _____

If *"No,"* please continue.

d. Does your state plan on implementing an antipsychotic monitoring program in the future?

- ○ Yes, please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children.

  _____

  _____

  _____

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

  _____

  _____

  _____

2. Does your state have a documented program in place to manage and monitor the appropriate use of antipsychotic drugs in individuals over the age of 18 receiving home and community-based services (as defined in section 9817(a)(2)(B) of Public Law 117–2)?

   - ○ Yes
   - ○ No

   If *"Yes,"* please continue.

   a. Does your state have edits in place to monitor (check **all** that apply):

   - ☐ Dosage
   - ☐ Indication
   - ☐ Polypharmacy
   - ☐ Other, please explain.

     _____

     _____

     _____

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

   _____

If *"No,"* please continue.

c. Does your state plan on implementing an antipsychotic monitoring program in the future?

- ○ Yes, please specify when you plan on implementing a program.

- ○ No, please explain why you will not be implementing a program.

3. Does your state have a documented program in place to manage and monitor the appropriate use of antipsychotic drugs in individuals over the age of 18 residing in institutional care settings (including nursing facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases, inpatient psychiatric hospitals, and other such institutional care settings)?

   - ○ Yes
   - ○ No

   If *"Yes,"* please continue.

   a. Does your state monitor (check **all** that apply):
      - ☐ individuals over the age of 18 residing in nursing facilities
      - ☐ individuals over the age of 18 residing in intermediate care facilities for individuals with intellectual disabilities
      - ☐ individuals over the age of 18 residing in institutions for mental diseases
      - ☐ individuals over the age of 18 residing in patient psychiatric hospitals
      - ☐ individuals over the age of 18 residing in other such institutional care settings. Please explain.

If your state does not monitor all of the above, please explain why not.

b. Does your state have edits in place to monitor (check **all** that apply):

- ☐ Dosage
- ☐ Indication
- ☐ Polypharmacy
- ☐ Other, please explain.

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

If *"No,"* please continue.

d. Does your state plan on implementing an antipsychotic monitoring program in the future?

- ○ Yes, please specify when you plan on implementing a program.

- ○ No, please explain why you will not be implementing a program.

STIMULANTS

4. Does your state have a documented program in place to manage and monitor the appropriate use of stimulant drugs in children?

   ○ Yes
   ○ No

   If *"Yes,"* please continue.

   a. Does your state manage and monitor:

      ○ Only children in foster care under 18 y.o.
      ○ **All** children including foster care under 18 y.o.
      ○ Other, please explain.

   b. Does your state have edits in place to monitor (check **all** that apply):

      ☐ Child's age
      ☐ Dosage
      ☐ Indication
      ☐ Polypharmacy
      ☐ Other, please explain.

   c. Please briefly explain the specifics of your documented stimulant monitoring program(s).

   If *"No,"* please continue.

d. Does your state plan on implementing a stimulant monitoring program in the future?

- ○ Yes, please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.

_____

_____

_____

- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

_____

_____

_____

ANTIDEPRESSANTS

5. Does your state have a documented program in place to manage and monitor the appropriate use of antidepressant drugs in children?

- ○ Yes
- ○ No

If *"Yes,"* please continue.

a. Does your state manage and monitor:

- ○ Only children in foster care under 18 y.o.
- ○ **All** children including foster care under 18 y.o.
- ○ Other, please explain.

_____

_____

_____

b. Does your state have edits in place to monitor (check **all** that apply):

- ☐ Child's age
- ☐ Dosage
- ☐ Indication

- ☐ Polypharmacy
- ☐ Other, please explain.

_____

_____

_____

c. Please briefly explain the specifics of your documented antidepressant monitoring program(s).

_____

_____

_____

If *"No,"* please continue.

d. Does your state plan on implementing a stimulant monitoring program in the future?

- ○ Yes, please specify when you plan on implementing a program to monitor the appropriate use of antidepressant drugs in children.

_____

_____

_____

- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of antidepressant drugs in children.

_____

_____

_____

MOOD STABILIZERS

6. Does your state have a documented program in place to manage and monitor the appropriate use of mood stabilizing drugs in children?

   - ○ Yes

○ No

If *"Yes,"* please continue.

a. Does your state manage and monitor:

- ○ Only children in foster care under 18 y.o.
- ○ **All** children including foster care under 18 y.o.
- ○ Other, please explain.

_____

_____

_____

b. Does your state have edits in place to monitor (check **all** that apply):

- ☐ Child's age
- ☐ Dosage
- ☐ Indication
- ☐ Polypharmacy
- ☐ Other, please explain.

_____

_____

_____

c. Please briefly explain the specifics of your documented mood stabilize r monitoring program(s).

_____

_____

_____

If *"No,"* please continue.

d. Does your state plan on implementing a mood stabilizer monitoring program in the future?

- ○ Yes, please specify when you plan on implementing a program to monitor the appropriate use of mood stabilizing drugs in children.

_____

_____

_____

- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of a mood stabilizing drugs in children.

_____

_____

_____

ANTIANXIETY/SEDATIVES

7. Does your state have a documented program in place to manage and monitor the appropriate use of antianxiety/sedative drugs in children?

   - ○ Yes
   - ○ No

   If *"Yes,"* please continue.

   a. Does your state either manage and monitor:

      - ○ Only children in foster care under 18 y.o.
      - ○ **All** children including foster care under 18 y.o.
      - ○ Other, please explain.

      _____

      _____

      _____

   b. Does your state have edits in place to monitor (check **all** that apply):

      - ☐ Child's age
      - ☐ Dosage
      - ☐ Indication
      - ☐ Polypharmacy
      - ☐ Other, please explain.

      _____

      _____

      _____

c. Please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).

_____

_____

_____

If *"No,"* please continue.

d. Does your state plan on implementing an antianxiety/sedative monitoring program in the future?

O Yes, please specify when you plan on implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.

_____

_____

O No, please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.

_____

_____

_____

IX. INNOVATIVE PRACTICES

1. Does your state participate in any **demonstrations** or have any **waivers** to allow importation of certain drugs from Canada or other countries that are versions of FDA- approved drugs for dispensing to Medicaid beneficiaries?

   ○ Yes, please explain.

   _____

   _____

   _____

   ○ No

2. **Summary 5 – Innovative Practices**

   Innovative Practices Summary should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing). Please describe in detailed narrative below 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 (i.e., disease management, academic detailing, automated PA, continuing education programs).

   _____

   _____

   _____

   _____

X. MANAGED CARE ORGANIZATIONS (MCOs)

1. How many MCOs are enrolled in your state Medicaid program?

   _____MCO(s) (Insert the number of MCOs in the space provided including 0 if none)

   If "Zero" or "None", please skip the rest of this section.

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

   - ○ Yes
   - ○ No
   - ○ Partial

   If "Partial," please check what categories of medications are carved out of managed care benefits and handled by your FFS program:

   - ☐ Mental health medications
   - ☐ MAT
   - ☐ Opioids
   - ☐ Clotting factors
   - ☐ Other, please specify the drug categories.

   _____

   _____

   _____

3. Contract updates between state and MCOs addressing DUR provisions in Section 1004 Support for Patients and Communities Act are required based on 1902(oo). If covered outpatient drugs are included in an MCO's covered benefit package, has the state updated their MCOs' contracts for compliance with Section 1004 of the SUPPORT for Patients and Communities Act?

   - ○ Yes, contracts are updated to address each provision. Please specify effective date:

     _____

   - ○ No, contracts are not updated, please explain why not.

     _____

     _____

a. Is the state complying with federal law and monitoring MCO compliance on the SUPPORT for Patients and Communities Act provisions?

- ○ Yes, state is complying with federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions. Please explain monitoring activities.

_____

_____

_____

- ○ No, please explain why not.

_____

_____

_____

4. Does the state use a single PBM/PBA if the MCO has a drug benefit?

- ○ Yes
- ○ No
- ○ N/A

5. Does the state set requirements for the MCO's pharmacy benefit (i.e. same preferred drug list, same ProDUR/RetroDUR)?
   - ○ Yes
   - ○ No

   If *"Yes,"* please continue.

   a. Please check **all** requirements that apply below:

      - ☐ Formulary Reviews
      - ☐ Same PDL
      - ☐ Same ProDUR
      - ☐ Same RetroDUR
      - ☐ No state PDL

   b. Please briefly explain your policy.

_____

_____

If *"No,"* does your state plan to set standards in the future?

- ○ Yes
- ○ No, please explain.

6. Is the RetroDUR program operated by the state, by the MCOs or does your state use a combination of state interventions as well as individua l MCO interventions?

   - ○ State operated
   - ○ MCO operated
   - ○ State uses a combination of state interventions as well as individual MCO interventions

7. Indicate how the state oversees the FFS and MCO RetroDUR programs? Please explain the oversight process.

8. How does the state ensure MCO compliance with DUR requirements described in Section 1927(g) of the Act and 42 C.F.R part 456, subpart K?

9. Did **all** of your managed care plans submit their DUR reports?

   - ○ Yes
   - ○ No, please explain why not.

XI. EXECUTIVE SUMMARY

Executive Summary should provide a brief overview of your program. It should describe FFY 2024 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.