Idaho Medicaid Drug Utilization Review Program

20 October 2016
Annual DUR Report Highlights

Federal Fiscal Year 2015
Background

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.
Top 10 PA Requests by Drug Name

- duloxetine
- topiramate
- Strattera
- lamotrigine
- ondansetron
- tretinoin
- Intuniv
- Advair
- oxycodone
- Lyrica
Top 10 PA Requests by Drug Class

- Anticonvulsants
- Psychostimulants-Antidepressants (duloxetine, Strattera, Intuniv)
- Narcotic Analgesics
- Ataractic-Tranquilizers (second generation antipsychotics)
- Bronchial Dilators (Advair, montelukast, beta agonists)
- Antinauseants
- Anti-Ulcer Preps/Gastrointestinal Preps
- All Other Dermatologicals
- Amphetamine Preparations
- CNS Stimulants (methylphenidate, Nicoderm and Chantix)
Top 5 Claim Denial Reasons

- DUR Reject Error
- Plan limitations exceeded
- Submit bill to other processor or primary payor
- Prior Authorization Required
- Product/Service Not Covered
## Top 10 Drug Names by Amount Paid/ Percent of Total spend

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Percent of Total Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify</td>
<td>9.34%</td>
</tr>
<tr>
<td>methylphenidate ER</td>
<td>2.43%</td>
</tr>
<tr>
<td>Invega Sustenna</td>
<td>2.28%</td>
</tr>
<tr>
<td>Latuda</td>
<td>1.96%</td>
</tr>
<tr>
<td>Adderall XR</td>
<td>1.80%</td>
</tr>
<tr>
<td>Vyvanse</td>
<td>1.77%</td>
</tr>
<tr>
<td>Harvoni</td>
<td>1.75%</td>
</tr>
<tr>
<td>Strattera</td>
<td>1.70%</td>
</tr>
<tr>
<td>Proair HFA</td>
<td>1.57%</td>
</tr>
<tr>
<td>Lantus Solostar</td>
<td>1.39%</td>
</tr>
</tbody>
</table>
Top 10 Drug Names by Claim Count/Percent of Total Claims

- hydrocodone-acetaminophen 3.86%
- amoxicillin 2.86%
- omeprazole 2.40%
- Proair HFA 2.18%
- sertraline 1.61%
- montelukast sodium 1.60%
- levothyroxine sodium 1.56%
- trazodone 1.54%
- azithromycin 1.52%
- fluoxetine 1.49%
## Retrospective Educational Outreach Summary

<table>
<thead>
<tr>
<th>Study</th>
<th>Profiles Reviewed</th>
<th>Letters Sent/Calls Made</th>
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</thead>
<tbody>
<tr>
<td>Buprenorphine and paying cash for opioid (January 2015)</td>
<td>212</td>
<td>20</td>
</tr>
<tr>
<td>Multiple dosage forms of ziprasidone</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Gemfibrozil and Statins concurrently</td>
<td>62</td>
<td>55 prescribers 20 pharmacies</td>
</tr>
<tr>
<td>Buprenorphine and paying cash for opioid (July 2015)</td>
<td>241</td>
<td>31</td>
</tr>
<tr>
<td>Buprenorphine and concomitant benzodiazepine</td>
<td>241</td>
<td>57</td>
</tr>
<tr>
<td>Multiple dosage forms of aripiprazole</td>
<td>74</td>
<td>74</td>
</tr>
</tbody>
</table>
DUR Board Activities

- Buprenorphine use
- Narcotic analgesic studies
- Use of psychotropic medications in foster children
- Hepatitis C
- Prior Authorization review for Synagis medical and pharmacy claims
- Hospice
- Botulinum Toxin
- Acne
DUR Board Activities- 2

- Truvada
- Multiple dosage forms of ziprasidone prescribed concomitantly
- Oxycodone
- Methadone
- Colcrys
- Hydrocodone compound products
- Continuous oral plus injectable atypical antipsychotics
- Multiple dosage forms of aripiprazole prescribed concomitantly
- Gemfibrozil and statin interaction
Generic Utilization

- 80.2% utilization
- $ 41,387,476 (23%)
Cost Savings/Cost Avoidance
$ 41,202,018

• Prospective Review
  • Reversed claims not resubmitted cost savings
    • $ 31,637,921

• Retrospective Review
  • Hepatitis C Cost Avoidance $ 8,140,000
  • Hospice Cost Avoidance $ 20,000
  • Botulinum toxin Cost Avoidance $ 57,900
  • Hydrocodone/APAP Scheduling Switch $ 104,468
  • Synagis Cost Avoidance $ 1,241,730

  Total Retrospective Cost Savings $ 9,564,098
Interesting Questions That May Direct Future Activities

- Does the state or the state’s Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS?
- Has your MMIS been designed to incorporate covered outpatient physician administered drugs in prospective DUR?
- Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries?
- Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers?
- Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by pharmacy providers?
- Do you have a documented process in place that identifies potential fraud or abuse of non-controlled drugs by beneficiaries?
- Do you have an algorithm in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?
Innovative Practices

- Buprenorphine direct to the prescriber intervention
- Pharmacist case management
  - Hepatitis C
  - Hemophilia
- Foster Children Collaborative Practice
- Oversight of physician administered drugs
Executive Summary Highlights

- Idaho Medicaid and Magellan Partnership
- Internal PA Call Center
- DUR Outcome Studies on PDL Impact
- Lack of Legislative Restriction
- Physician Administered Drugs
- 18 RetroDUR Studies
- Narcotic Analgesics and Psychotropics in Children Emphasis
- Generic Utilization – not best measure
- > 80 Drug Classes on Preferred Drug List
Ongoing Reviews

- Narcotic Prescribing Improvement Project
  - Top 150 Utilizers
  - Idaho Opioid Equivalent Dosing Project
  - Hospitalization Claims for Top 150 Narcotic Utilizers 2013-2016
  - Methadone
- Buprenorphine and benzodiazepine concomitant use
- Foster Children
- Hepatitis C Update
- Second-Generation Antipsychotic Use in children < 6 years old
Top 150 Utilizers of Opioids Intervention

October 2016
DUR Top 150 Utilizers

- Generated profiles for the top 150 recipients by total narcotic claim count from the recipients who had at least one narcotic claim in each of the 24 months of the period ending August 31, 2015
- Time Period: March 1, 2015 through August 31, 2015
- All profiles were hand reviewed by Idaho Medicaid Pharmacists in conjunction with the patient’s PMP report
- 7 patients had a cancer diagnosis, but were kept in evaluation as all but one patient also had chronic non-malignant pain unrelated to cancer diagnosis
- Most common diagnoses – chronic pain and lumbago
- Daily Morphine Equivalents
  - Range 15-2244 mg
  - Average 260 mg
## Results

<table>
<thead>
<tr>
<th>Abuse Diagnosis</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lock-In</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>&gt; 1 Long-Acting</td>
<td>9</td>
<td>6%</td>
</tr>
<tr>
<td>&gt; 1 Short-Acting</td>
<td>48</td>
<td>32%</td>
</tr>
<tr>
<td>Short-acting without Long-acting</td>
<td>35</td>
<td>23%</td>
</tr>
<tr>
<td>Short Acting&gt; 50% total Daily MED</td>
<td>46</td>
<td>31%</td>
</tr>
<tr>
<td>MED &gt; 120</td>
<td>91</td>
<td>61%</td>
</tr>
<tr>
<td>Concurrent Benzodiazepine</td>
<td>82</td>
<td>55%</td>
</tr>
<tr>
<td>Benzo same prescriber as Opioids</td>
<td>54</td>
<td>66%</td>
</tr>
<tr>
<td>Opioids Paid Outside of Medicaid (Cash)</td>
<td>51</td>
<td>34%</td>
</tr>
</tbody>
</table>
Intervention In Process

- Doing in batches by highest morphine equivalent dose
- Re-evaluating for most recent 3 months
- Intervention
  - Cover Letter
  - Targeted Paragraphs based on actual identified issues
Cover Letter Key Points

- Patient identified as high utilizer
- P&T and DUR have made specific recommendations
- Based on CDC Guideline – this patient is not meeting best practice
- Limitations on dosage, therapeutic duplication, prescription quantities and duration of therapy will be implemented within the next year
- Prior authorization with treatment plan will be required including functional goals, monitoring and tapering schedule
Identified Problem List

- Paragraphs chosen for actual problems identified for each individual patient

- Problems (paragraphs)
  - Treatment Duration
  - Opioid Dosage
  - Multiple Prescribers
  - Cash paying for additional opioids
  - Benzodiazepine concomitant with opioid
Format

- Findings
- Guidelines/Evidence
- Recommendations/Action Needed
Treatment Duration Key Points

- Greater > 1 year
- Evaluate for clinically meaningful improvements in both pain and function
- Maximize
  - non-pharmacological interventions
  - non-opioid medications
- If benefits do not outweigh harms taper to a lower dosage and/or discontinue
Opioid Dosage Key Points

- Includes calculated morphine equivalent daily dose calculated for last 3 months
- Individualized into sub-categories contributing to high dosage
  - The use of more than one short-acting opioid concurrently for greater than 2 months
  - Use of more than one long-acting opioid concurrently for greater than 2 months
  - Use of a combination of both long-acting and short-acting agents for greater than 2 months
  - Inclusion of a round the clock short-acting opioid
Opioid Dosage Key Points (cont.)

• Recommendations
  • Consolidate to not more than one long-acting and one short-acting opioid
  • Evaluate the monthly quantity of the short-acting opioid.
    • patient on a short-acting opioid with a dosing schedule of four times daily as needed should not require 120 tablets for 30 days of the month.
  • Taper to a safer dosage
  • Perform frequent urine tests
  • Consider diversion such as sharing or selling
  • Evaluate for possible substance use disorder
Multiple Prescribers Key Points

- Review attached PMP
- Coordinate care with other prescribers
Paying Cash Key Points

• Same Prescriber
  • If >120 daily morphine mg equivalents
    • Taper to a safer dosage
    • Perform frequent urine tests
    • Consider diversion such as sharing or selling
    • Evaluate for possible substance use disorder

• Different Prescriber
  • Coordinate care (name is on attached PMP)
Concurrent Benzodiazepines and Opioids Key Points

- FDA black box warning
- Higher risk for adverse events
- Current recommendations for treatment of anxiety disorders
Top Patients

• Of top 26 patients (by total daily morphine equivalent dose)
  • 13 were methadone users
    • Utilizing methadone intervention first
  • 3 were no longer using high doses
  • 10 were evaluated for Top 150 intervention
    • By definition all were receiving opioids > 1 year
    • 6 have > 1 short-acting agent
    • 0 have more than 1 long-acting agent
    • 0 have multiple prescribers
    • 7 are paying cash for additional opioids
    • 8 are receiving concomitant benzodiazepines
  • Morphine equivalents range from 265-900 mg
<table>
<thead>
<tr>
<th>ID</th>
<th>Greater than 1 yr</th>
<th>MED</th>
<th>&gt;1 SAO</th>
<th>&gt;1 LAO</th>
<th>RTC SAO</th>
<th>Multiple Prescribers</th>
<th>Cash</th>
<th>Benzo + Opioid</th>
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<tbody>
<tr>
<td>119</td>
<td>Yes</td>
<td>900 mg</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>97</td>
<td>Yes</td>
<td>900 mg</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>69</td>
<td>Yes</td>
<td>656 mg</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>106</td>
<td>Yes</td>
<td>720 mg</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<td>28</td>
<td>Yes</td>
<td>480 mg</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>43</td>
<td>Yes</td>
<td>413 mg</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>13</td>
<td>Yes</td>
<td>360 mg</td>
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<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>85</td>
<td>Yes</td>
<td>350 mg</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>142</td>
<td>Yes</td>
<td>265 mg</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>44</td>
<td>Yes</td>
<td>683 mg</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Morphine Milligram Equivalent (MME) of 90 is now the recommended goal by the CDC, a point to understand is that there is not just one MME Calculator:

- CMS MME Calculator
- Other MME Calculators
- Customized MME Calculator

Depending on number of recipients and workload may need to start at a higher MME and lower threshold as time goes on.
Idaho Opioid Equivalent Dosing Project

- Prior Authorization
- First Rx
- First Trax
- First IQ
- Reporting
Idaho Opioid Equivalent Dosing Project

• Prior Authorization
  • Develop criteria and set a threshold of a MME to begin
Magellan Rx Prior Authorization Criteria

- **Goal:** require a prior authorization if a patient exceeds the ≥90 Morphine Milligram Equivalence (MME) per day combined Short and Long acting narcotic agents
  - ≥90 MME per day is the CDC max daily dose recommendation
  - PA required for > 7 day supply

- **Universal Opioid Criteria, Short and Long Acting Narcotics**
  - Length of Authorization: 3-12months*, eligible for renewal
  - Cancer, Palliative, End of Life Care Pain, Sickle Cell: Authorization of up to 12 months
    - Short Acting Narcotics and Long Acting Narcotics approved for diagnosis of cancer pain, palliative/end-of-life care, or hospice
  - Other Pain: Authorization of up to 3 months
    - *If the claim is for ≤ 7 day supply then the claim will pay without a Prior Authorization required*
Magellan Rx Prior Authorization Criteria

Required for both Short and Long Acting Narcotics

1. Require diagnosis of moderate-severe pain

2. Physician attestation to consulting/participating in any applicable state Prescription Monitoring Program (PMP) prior to prescribing any medications, AND

3. Patient is not currently undergoing active treatment for opioid addiction, AND

4. Patient does not have a documented history of opioid addiction or abuse, AND

5. Physician attestation to having a treatment plan in place with the patient that addresses such things as the benefits and harms of opioid use, addiction, diversion, expectations and goals of treatment, and stipulations for continued treatment, such as functional improvement, a single opioid prescriber and/or regular dispensing pharmacy, AND

6. Physician attestation to completing a urine drug screen at least annually, with the most recent date of the test indicated as part of the requirements for approval (if not performed within the past 30 days, can deny or limit duration of approval)
Magellan Rx Prior Authorization Criteria

Short Acting and Long acting agents, additional specific requirements for each

- **Short Acting Agents:**
  1. > 7 days requested; authorize for 30 days only permitting the other authorization conditions listed above and below are satisfied
  2. Require reauthorization after 30 days. All above conditions apply

- **Long Acting Agents:**
  1. Must be chronic pain greater than 6 months in duration, AND
  2. Inadequately controlled on Short Acting Narcotic Opioid equivalent, AND
  3. Patient must require around-the-clock pain management
Magellan Rx Prior Authorization Criteria

Criteria to approve override of quantity limit ≥90 MME

- If greater than ≥ 90 MME requested,
  1. Physician justification as to why the high dose of opioid is necessary AND
  2. Why a lower dose will be inadequate

- **The following are some questions that can be asked and considered as to whether the therapy is appropriate for the patient**
  - What is the underlying condition causing the pain?
    - *The intent is to capture the response and be able to report on it*
  - Has the patient consulted with a pain specialist, prescriber specialty is in the same organ system as the primary pain diagnosis
    - If yes – “Approve”
    - If not – “Deny”
Idaho Opioid Equivalent Dosing Project

- First Rx
  - Capable of supporting standard and custom MME cumulative dosing limits, conversion factors, and drug lists
  - Future build out capabilities – targeting Q1 2017
    - CORE Team is scheduled to include an enhancement that will allow CSR’s, and PA Agents to view the claim(s) that exceeds the Quantity limit set by the client
Idaho Opioid Equivalent Dosing Project

- **First Trax** (Under Development 10/2016)
  1. First Trax enhancement to allow Prior Authorization agents and CSR’s to view:
     - MME of the incoming claim that exceeded the MME Quantity Limit
     - MME of each claim that contributed to the incoming claim to exceed the limit
     - Total Combined MME of all claims that contributed to the incoming claim to exceed the limit
  2. **Calculator**:
     - First Trax will have a Calculator functionality installed
       - Pulls information from relevant opioid claims only
       - Auto-populates calculator with necessary claims data
       - Enables the PA/CSR to change the value of some fields
Idaho Opioid Equivalent Dosing Project

- First IQ – RetroDUR
  - FIQ can be used for
    - Member identification only, or
    - FIQ can used to generate letters for to:
      - members, prescribers and/or pharmacies

- FIQ is highly flexible
  - Drug groups for criterion are defined within the application
  - Criterion and output can be customized at the client level
Idaho Opioid Equivalent Dosing Project

**Reporting**

- Currently using drug lists, MME Conversion Factors and the extrapolated chart for Methadone, as defined by another Magellan Rx Client.
- Specific to Idaho there were 34,869 non Methadone claims and 680 Methadone claims for a combined total of 35,549 Opioid claims during 3q2016 (based on the opioids as defined for the other Magellan Rx Client)
- There were 627 members who met or exceeded the daily MME of 300 during 3q2016. The breakdown is listed on the next slide. The Max Daily MME represented there is the highest daily MME that each of these members, who met or exceeded 300, reached on any given day(s). The allowance for an overlapping Rx was 3 days. Any overlapping utilization of at least 4 days, therefore, results in a combined MME.
Idaho Opioid Equivalent Dosing Project

- Reporting

<table>
<thead>
<tr>
<th>Max Daily MME</th>
<th># of Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>exactly 300</td>
<td>47</td>
</tr>
<tr>
<td>300 - 400</td>
<td>222</td>
</tr>
<tr>
<td>400 - 500</td>
<td>136</td>
</tr>
<tr>
<td>500 - 600</td>
<td>95</td>
</tr>
<tr>
<td>600 - 700</td>
<td>80</td>
</tr>
<tr>
<td>700 - 800</td>
<td>11</td>
</tr>
<tr>
<td>800 - 900</td>
<td>5</td>
</tr>
<tr>
<td>900 - 1000</td>
<td>6</td>
</tr>
<tr>
<td>1000 - 1500</td>
<td>16</td>
</tr>
<tr>
<td>1500 - 3380</td>
<td>9</td>
</tr>
</tbody>
</table>
Idaho Opioid Equivalent Dosing Project

- Next Steps
Hospitalization Claims for Top 150 Narcotic Utilizers 2013-2016

- 96 of the 150 patients had at least one hospitalization. There were a total of 300 hospitalizations in the 96 patients (averaging 3.1 hospitalizations per patient).

**Reason for admission**

Note: No patient specifically had an admission for “constipation.” The diagnosis of abdominal pain is potentially related to constipation but could be a myriad of other issues including appendicitis or cardiac issues. Plus only the primary reason for hospitalization was listed in this report.
Hospitalization Claims for Top 150 Narcotic Utilizers 2013-2016

- infection (54)
- orthopedic/spinal (50)
- altered mental status/weakness/fatigue (29)
- psychiatric issues (29)
- cardiac (23)
- respiratory (17)
- bleeding/clotting (15)
- abdominal pain (14)
- electrolytes/fluid level (11)
- OB/GYN (11)
- diarrhea/vomiting (10)
- drug overdose/withdrawal (9)
- pain (not abdominal) (9)
- rehab/surgical/trauma (8)
- diabetes (5)
- cancer (3)
- digestive disorder (1)
- obesity (1)
- Stevens-Johnson (1)
Hospitalization Claims for Top 150 Narcotic Utilizers 2013-2016

**Summary**: Only 14/300 (4.7%) of hospitalization admissions for Idaho Medicaid’s top narcotic utilizers (identified by claim count) listed abdominal pain as the primary reason for the hospitalization. This diagnosis is very non-specific and does not necessarily correlate with constipation as there are many etiologies for abdominal pain.
Hospitalization Claims for Top 150 Narcotic Utilizers 2013-2016

• Questions/Comments ???
Methadone DUR

Ongoing Review
October 20, 2016
Methadone

Growing Public Health Concern

- More than 16,500 people in the United States die each year from opioid-related prescription drug overdoses.
- Methadone is responsible for nearly 1/3 of these deaths but accounts for only 2% of opioid pain reliever prescription.

Methadone

Preferred pain reliever for most state Medicaid programs.

- Idaho Medicaid removed Methadone preferred status October 2015.
- Prior authorization required
- Informed methadone providers of implementation of methadone prior authorization and requested tapering off methadone.
Methadone

Methadone Prior Authorization Request Forms

• **Methadone, Initial Request**
  • States initial criteria for review:
    • Failure of all alternative long acting narcotic agents.
    • Electrocardiogram (QTc interval documentation).
    • Pain score and functionality documentation.
    • Other active concurrent opioids (immediate release)
    • Documentation of failure/intolerance to non-opioid or opioid agents.
Methadone

- **Methadone, Reauthorization**
  - Emphasizes monitoring and recommends dose tapering:
    - Electrocardiogram (QTc interval annual review).
    - Doses greater than 40mg/day will require documentation of medical necessity and clinical reason why dose reduction cannot be employed.
    - History of failure/intolerance to non-opioid or other opioid agents.
    - Only prescribers who are familiar with methadone’s titration and risks, or those who are able to consult with a pain specialist or clinical pharmacist, should prescribe or make changes to methadone treatment.
  - Work in progress.
Methadone

Review of Methadone drug utilization after changing to non-preferred agent.

Calendar Quarters Reviewed:
4\textsuperscript{th} Quarter 2015 (Oct-Dec)
2\textsuperscript{nd} Quarter of 2016 (Apr-Jun)
3\textsuperscript{rd} Quarter of 2016 (Jul-Sept)
Methadone

![Methadone Chart]

- **Total Unique Prescribers**
- **Total Unique Patients**
- **Total Claims**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total Unique Prescribers</th>
<th>Total Unique Patients</th>
<th>Total Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>4th Q 2015</td>
<td>226</td>
<td>306</td>
<td>931</td>
</tr>
<tr>
<td>2nd Q 2016</td>
<td>195</td>
<td>255</td>
<td>761</td>
</tr>
<tr>
<td>3rd Q 2016</td>
<td>137</td>
<td>183</td>
<td>680</td>
</tr>
</tbody>
</table>
Methadone

Percentage of Patients Total Daily Dose

- Less than 40mg/day
- 40mg/day
- Greater than 40mg/day

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Less than 40mg/day</th>
<th>40mg/day</th>
<th>Greater than 40mg/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>4th Q 2015</td>
<td>53%</td>
<td>17%</td>
<td>30%</td>
</tr>
<tr>
<td>2nd Q 2016</td>
<td>58%</td>
<td>12%</td>
<td>30%</td>
</tr>
<tr>
<td>3rd Q 2016</td>
<td>55%</td>
<td>13%</td>
<td>32%</td>
</tr>
</tbody>
</table>
Methadone

Total Methadone Claims

- Total Claims vs Time (Oct-15 to Sep-16)
- Graph shows a downward trend in total claims over time.

58
Methadone

Patients taking more than 40 mg/day

- Average #tablets/day=7
- Range: 5-13 tablets/day (50 mg-130 mg/day)

Morphine Equivalents Daily (MED)*

- 30 mg=240
- 40 mg=320
- 50 mg=500
- 60 mg=600
- 70 mg=840
- 130 mg=1560

*Opioid Dose Calculator: http://www.agencymeddirectors.wa.gov/opioiddosing.asp
(Washington State Agency Medical Directors' Group)
Methadone

In conclusion:

- Methadone utilization has decreased since incorporation of non-preferred status and prior authorization requirements.
- Total providers, total patients, and total claims have decreased.
- No change noted with percentage of patients on greater than 40 mg/day of methadone.
Methadone

- Questions/Comments??
Buprenorphine and benzodiazepine concomitant use
Buprenorphine and Benzodiazepine DUR

- **Suboxone Package Insert**
  
  - Buprenorphine in combination with benzodiazepines or other CNS depressants including alcohol has been associated with significant respiratory depression and death.

  - Patients should be warned of the potential of self-administration of benzodiazepines or other depressants while under treatment with Suboxone.
Buprenorphine and Benzodiazepine DUR

- Payment block went into effect 1/6/16 requiring prior authorization for payment for either buprenorphine or benzodiazepine with overlapping days of service.
Buprenorphine and Benzodiazepine DUR

- PMP Interconnect Search
  - Eighteen States now on the list (must select each individual state to search) – including Idaho

  Arizona
  Colorado
  Illinois
  Indiana
  Kansas
  Massachusetts
  Michigan
  Minnesota
  Mississippi

  Nevada
  New Mexico
  North Dakota
  Ohio
  Rhode Island
  South Carolina
  Texas
  Utah
Buprenorphine and Benzodiazepine DUR

New Federal Regulations Increase Limit Rule to 275 Buprenorphine Patients

Effective Date: 8/08/2016
Physicians who have prescribed buprenorphine to 100 patients for at least one year can now apply to increase their patient limits to 275 under new federal regulations.

To be considered for the higher limit, complete the Online Request for Patient Limit Increase. SAMHSA reviews applications within 45 days of receipt.

Document Citation: 81 FR 44711
Many commenters wrote about the eligibility and role of nurse practitioners and/or physician assistants in prescribing buprenorphine. The vast majority of these commenters suggested that nurse practitioners and physician assistants should be allowed to prescribe buprenorphine under the new regulation.
Questions related to expanding eligible prescribers are outside the scope of this rulemaking; the statute limits who is eligible to prescribe buprenorphine for MAT.

21 U.S.C. 823(g)(2) limits the practitioners eligible for waiver in this context to physicians, and, therefore, HHS is not authorized to include other types of providers in this rule. However, HHS recognizes the issues raised by commenters and the President's FY 2017 Budget proposes a buprenorphine demonstration program to allow advance practice providers to prescribe buprenorphine. This would allow HHS to begin testing other ways to improve access to buprenorphine throughout the country.
Buprenorphine and Benzodiazepine DUR

![Graph showing total number of participants on oral buprenorphine and those who paid cash for an opioid while on oral buprenorphine.]

- **Total # of participants on oral buprenorphine**
- **Participants who paid cash for an opioid while on oral buprenorphine**
Buprenorphine and Benzodiazepine DUR

- **buprenorphine patients**
- **concomitant benzo while on buprenorphine**
- **cash paying opioids while on buprenorphine**
- **cash paying opioids AND concomitant benzo while on buprenorphine**
Buprenorphine and Benzodiazepine DUR

Buprenorphine and benzodiazepine June 2016 – August 2016

- **26** Buprenorphine prescriber justified ongoing benzo usage
- **8** Buprenorphine prescriber discontinued or is weaning benzo
- **2** Patient no longer on buprenorphine but continuing benzo
- **19** Paying cash for benzo while on buprenorphine (see detail next slide)
Detail on patients paying cash for benzo while on buprenorphine but no PA submitted

- MD aware/ok with it: 10
- Patient told to discontinue benzo: 2
- Procedural, 1x fill: 2
- No details known: 5
Prescribers who have requested ongoing benzodiazepine usage in patients on buprenorphine (n=11)
Which benzodiazepines are requested for long-term use?

- clonazepam
- alprazolam
- temazepam
- lorazepam

- clonazepam: 15
- alprazolam: 8
- temazepam: 3
- lorazepam: 3
Buprenorphine and Benzodiazepine DUR

- Questions/Comments ???
Foster Children
Hepatitis-C DUR

Hepatitis-C Requests
3rd Quarter 2016

Total Reviewed: 50
Approved: 13
Denied: 32
Pending Review: 5
Hepatitis-C DUR

Approved Patients
Mean Age=58 (47-63)

- Male, 9
- Female, 4
Hepatitis-C DUR

Approved Requests

*Drug*

<table>
<thead>
<tr>
<th>Drug</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harvoni</td>
<td>8</td>
</tr>
<tr>
<td>Epclusa</td>
<td>5</td>
</tr>
</tbody>
</table>

81
Hepatitis-C DUR

Approved Requests *Genotype*

- Genotype 1: 8
- Genotype 2: 1
- Genotype 3: 4
Hepatitis-C DUR

Approved Requests
*Liver Fibrosis Staging*

- F0: 8
- F1: 5
- F2: 5
- F3: 8
- F4: 5
Hepatitis-C DUR

Approved Requests
*Cirrhosis*

- No Cirrhosis: 23%
- History of Cirrhosis: 77%
Hepatitis-C DUR

Denied Patients
Mean Age=53 (28-66)

Female, 13
Male, 19
Hepatitis-C DUR

Denied Requests
*Drug*

- Harvoni: 17
- Epclusa: 8
- Sovaldi: 3
- Viekira Pak: 4
Hepatitis-C DUR

**Denied Request**

*Genotype*

- Genotype 1: 20
- Genotype 2: 4
- Genotype 3: 5
- Genotype 4: 1
- Genotype 6: 2

Total: 32
Hepatitis-C DUR

Denied Requests
*Liver Fibrosis Staging*

- F0: 8
- F1: 14
- F2: 2
- F3: 1
- Unknown: 1
- F4: 3
- F5: 2
Hepatitis-C DUR

Denied Requests

- Did Not Meet Criteria: 26
- Active Substance Abuse: 4
- Incomplete Followup: 2
Hepatitis-C DUR

Total Amount Paid
3rd Quarter 2016

- Epclusa: $168,091, 8 claims
- Harvoni: $199,444, 8 claims
- Sovaldi: $397,946, 15 claims
- Daklinza: $832,769, 27 claims

Total: $1,598,250
Hepatitis-C DUR
Epclusa® (Sofosbuvir 400mg / Velpatasvir 100mg)
- Pangenotypic, single dose regimen for adults with genotype 1-6 chronic HCV infection.
- HCV genotype 2 and 3, without the need for ribavirin.
- Treatment duration of 12 weeks for patients without cirrhosis or with compensated cirrhosis (Child-Pugh A), and in combination with ribavirin (RBV) for patients with decompensated cirrhosis (Child-Pugh B or C).
Hepatitis-C DUR

Current recommendations for HCV treatment Criteria

• Preferred agents for Genotype 1 HCV treatment:
  • Harvoni®
  • Viekira PAK™
  • Viekira XR™

• Preferred agents for Genotype 2,3 HCV treatment:
  • Epclusa®

• Clinical criteria changed to fibrosis score of F2 to F4.
Hepatitis-C DUR

- Questions/Comments??
Atypical (Second Generation) Antipsychotics In Children < 6 years

September 2016 Update
Drug class is widely used to treat children enrolled in Medicaid

Second Generation Antipsychotics (SGA) have serious side effects

Little clinical research has been done in children
Recommendations to CMS by the OIG

Work with States to:

- Perform utilization reviews of SGAs prescribed to children
- Conduct periodic reviews of medical records associated with claims for SGAs prescribed to children
- Consider other methods of enhanced oversight of SGAs prescribed to children, such as implementing peer review programs
Previously

• Reviewed medication profiles of children that were 5 years or younger during calendar year 2015 and had at least one claim for a second generation (atypical) antipsychotic

• 49 children met criteria
### Presumed Indication

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>None Listed</td>
<td>7</td>
</tr>
<tr>
<td>Other Disorders of Psychological Development</td>
<td>1</td>
</tr>
<tr>
<td>Intermittent Explosive Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Explosive Personality</td>
<td>1</td>
</tr>
<tr>
<td>Emotional Disturbance of Childhood</td>
<td>1</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>5</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>2</td>
</tr>
<tr>
<td>Bipolar</td>
<td>2</td>
</tr>
<tr>
<td>Sleep Disturbance</td>
<td>3</td>
</tr>
<tr>
<td>Pervasive Development Disorder</td>
<td>3</td>
</tr>
<tr>
<td>Autism</td>
<td>19</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>2</td>
</tr>
<tr>
<td>ADHD</td>
<td>2</td>
</tr>
</tbody>
</table>
Supported Indication

- FDA Indication: No
- Compendia: No
- Evidence/Guideline Supported: No
# Summary of Indications

## Indication Evaluation

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Number Meeting</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA Approved</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>FDA Approved Indication, but below age</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>Compendia Supported</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Compendia Supported, but below age</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Published Quality Evidence/Guidelines</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Evidence/Guidelines, but below age</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>Indication Unknown</td>
<td>7</td>
<td>14%</td>
</tr>
</tbody>
</table>

## Summary

- Supported Indication: 27%
- Indication not supported: 22%
- Indication unknown: 14%
- Yes indication, no age: 37%

- Total: 100%
CMS Antipsychotic Drug Use in Children Affinity Group

• Provide a forum to share strategies, successes and challenges to improve the quality of care for children prescribed antipsychotic drugs

• Identify a variety of methods States can use to assess Second Generation Antipsychotic (SGA) drug utilization

• Improve communication and collaboration between States and stakeholder partners to support enhanced review of SGA drugs

• Encourage cooperative Focus Studies and Performance Improvement Projects between States and their External Quality Review Organizations (EQROs) and managed care organizations
Idaho Focus: Second Generation Antipsychotics in Children < 6 Years Old

- Overall Goal: Ensure that use of second generation antipsychotics in children < 6 years old is appropriate with positive outcomes.

**Measurement:**

- Supported Indication
  - Calendar year 2015 (baseline) = 27%
  - Target rate: 90%
- Small Group Participation: Authorization
September 2016

- Survey (see handout)
  - For more complete information
  - Included request for most recent progress note
- Limited to those still under 6 (5 years or less)
- 17 Surveys sent
  - 15 returned
    - 13 complete
      - 1 patient no longer being seen by prescriber
      - 2 no longer being followed by prescriber
      - 2 missing pages or progress notes
    - 2 not returned
      - 1 neither practitioner nor patient at clinic (but scripts being filled)
## Prescriber Specialty

- **Child/Adolescent Psychiatrist**: 4
- **Pediatrician**: 1
- **Physician Assistant**: 1
- **Nurse Practitioner**: 7

### Current Prescriber Started Medication?
- **Yes**: 8
- **Yes, with specialist consult**: 1 (pediatrician)
- **No**: 4
  - **Specialty starting**
    - **Child/Adolescent Psychiatrist**: 2
    - **Family Medicine Physician**: 1
    - **Nurse Practitioner**: 1
Primary Diagnosis

- Autism Spectrum Disorder/PDD 8
- Bipolar Disorder 2
- Oppositional Defiant Disorder 4
- ADHD 1
- Sleep Disorder 1
- Other Disruptive Disorder
  - Self injurious behavior 1
  - Emotional disturbance of childhood 2

Presumed indication from claims review matched survey indication in 9/13 incidences
Non-Pharmacological Treatments Tried BEFORE Psychotherapy

- Behavioral Therapy: 10
- Cognitive Therapy: 1
- Family-Based Therapy: 5
- None: 3
Main Target Symptom(s)

- Aggression  9
- Irritability without aggression  2
- Mood Instability  5
- Anxiety  1
- Impulsivity  6
- Self-injurious behavior  6
- Sleep Problems/Insomnia  7
Previously Tried Medication Classes

- Alpha-adrenergic blocker: 6
- Stimulant: 5
- Non-Stimulant ADHD agent: 2
- Antidepressant: 4
- Different Antipsychotic: 1*
- None: 3
- Unknown: 1

* One practitioner tried chlorpromazine, promethazine, haloperidol on same patient
Current Additional Medication Classes

- Alpha Adrenergic agent 5
- Stimulant 4
- Non-Stimulant ADHD agent 1
- Antidepressant 1
- No other psychiatric medication 2
Additional Non-Pharmacological Treatments

- Behavioral-based therapy 2
- Occupational/Speech/Developmental 5
- IEP 1
- Office visit with behavioral psychotherapy 1
- Respite 1
- Family Training 1
- Home environmental controls 1
- Helmet 1
Metabolic Monitoring

- Weights
  - Each visit: 2
  - Monthly: 1
  - Quarterly: 3
  - Biyearly: 2
  - Random: 1

- BMI
  - Each visit: 2
  - Monthly: 1
  - Quarterly: 2

- Lipid/Glucose Labs
  - Baseline: 1
  - Quarterly: 2
  - Yearly: 6
  - Random (when sedated): 1
Next Steps

• Evaluate each patient for continuation

• Consultation Process with Tellagen (External Quality Review Organization)

• Develop PA criteria, Form and Process
Current Interventions/Outcomes

Studies

- Opioid and benzodiazepine concomitant use
- Low dose quetiapine
A U.S. Food and Drug Administration (FDA) review has found that the growing combined use of opioid medicines with benzodiazepines or other drugs that depress the central nervous system (CNS) has resulted in serious side effects, including slowed or difficult breathing and deaths. Opioids are used to treat pain and cough; benzodiazepines are used to treat anxiety, insomnia, and seizures. In an effort to decrease the use of opioids and benzodiazepines, or opioids and other CNS depressants, together, we are adding Boxed Warnings, our strongest warnings, to the drug labeling of prescription opioid pain and prescription opioid cough medicines, and benzodiazepines.
Opioid and benzodiazepine concomitant use

Health care professionals should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. Avoid prescribing prescription opioid cough medicines for patients taking benzodiazepines or other CNS depressants, including alcohol.
Opioid and benzodiazepine concomitant use

**Patients** taking opioids with benzodiazepines, other CNS depressant medicines, or alcohol, and caregivers of these patients, should seek medical attention immediately if they or someone they are caring for experiences symptoms of unusual dizziness or lightheadedness, extreme sleepiness, slowed or difficult breathing, or unresponsiveness. Unresponsiveness means that the person doesn’t answer or react normally or you can’t wake them up. Talk with your health care professional if you have questions or concerns about taking opioids or benzodiazepines (see List of Prescription Opioid Pain and Cough Medicines, and List of Benzodiazepines and Other CNS Depressants).
Opioid and benzodiazepine concomitant use

Utilizing Magellan Rx First IQ Data and pulling for dates of 7/1/2016 – 9/30/2016:

<table>
<thead>
<tr>
<th>Select Criteria</th>
<th>Criteria Id</th>
<th>Criteria Description</th>
<th>Total Exceptions</th>
<th>Total Members</th>
<th>Total Physicians</th>
<th>Total Pharmacists</th>
<th>Total Claims</th>
<th>Total Paid($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>7729</td>
<td>Concomitant use of opioids and benzodiazepines</td>
<td>2,018</td>
<td>2,018</td>
<td>1,503</td>
<td>302</td>
<td>10,306</td>
<td>$404,632.09</td>
</tr>
</tbody>
</table>
Opioid and benzodiazepine concomitant use

- Discussion on Concomitant Benzodiazepines and Opiates
- How to proceed?
Low dose quetiapine

- **Per package insert:**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Initial Dose</th>
<th>Recommended Dose</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia-Adults (2.2)</td>
<td>25 mg twice daily</td>
<td>150-750 mg/day</td>
<td>750 mg/day</td>
</tr>
<tr>
<td>Schizophrenia-Adolescents (13-17 years) (2.2)</td>
<td>25 mg twice daily</td>
<td>400-800 mg/day</td>
<td>800 mg/day</td>
</tr>
<tr>
<td>Bipolar Mania- Adults Monotherapy or as an adjunct to lithium or divalproex (2.2)</td>
<td>50 mg twice daily</td>
<td>400– 800 mg/day</td>
<td>800 mg/day</td>
</tr>
<tr>
<td>Bipolar Mania- Children and Adolescents (10 to 17 years), Monotherapy (2.2)</td>
<td>25 mg twice daily</td>
<td>400-600 mg/day</td>
<td>600 mg/day</td>
</tr>
<tr>
<td>Bipolar Depression-Adults (2.2)</td>
<td>50 mg once daily at bedtime</td>
<td>300 mg/day</td>
<td>300 mg/day</td>
</tr>
</tbody>
</table>
**Low dose quetiapine**

- **Titration schedule per package insert:**

<table>
<thead>
<tr>
<th>Schizophrenia-Adults</th>
<th>Day 1: 25 mg twice daily. Increase in increments of 25 mg-50 mg divided two or three times on Days 2 and 3 to range of 300-400 mg by Day 4. Further adjustments can be made in increments of 25–50 mg twice a day, in intervals of not less than 2 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia- Adolescents (13-17 years)</td>
<td>Day 1: 25 mg twice daily. Day 2: Twice daily dosing totaling 100 mg. Day 3: Twice daily dosing totaling 200 mg. Day 4: Twice daily dosing totaling 300 mg. Day 5: Twice daily dosing totaling 400 mg. Further adjustments should be in increments no greater than 100 mg/day within the recommended dose range of 400-800 mg/day.</td>
</tr>
</tbody>
</table>
**Low dose quetiapine**

- **Titration schedule per package insert:**

<table>
<thead>
<tr>
<th>Bipolar Mania - Adults Monotherapy or as an adjunct to lithium or divalproex</th>
<th>Day 1: Twice daily dosing totaling 100 mg. Day 2: Twice daily dosing totaling 200 mg. Day 3: Twice daily dosing totaling 300 mg. Day 4: Twice daily dosing totaling 400 mg. Further dosage adjustments up to 800 mg/day by Day 6 should be in increments of no greater than 200 mg/day.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Mania - Children and Adolescents (10 to 17 years), Monotherapy</td>
<td>Day 1: 25 mg twice daily. Day 2: Twice daily dosing totaling 100 mg. Day 3: Twice daily dosing totaling 200 mg. Day 4: Twice daily dosing totaling 300 mg. Day 5: Twice daily dosing totaling 400 mg. Further adjustments should be in increments no greater than 100 mg/day within the recommended dose range of 400-600 mg/day. Based on response and tolerability, may be administered three times daily.</td>
</tr>
</tbody>
</table>
Low dose quetiapine

- Dose titration is quick – by day 3, the daily dose is > 100mg regardless of diagnosis

- Profiles were pulled of patients that had three or more fills of quetiapine 25mg, 50mg, or 100mg tablet strengths in 90 days.

- 565 patients were identified. Medication profiles were reviewed of 100 of these patients due to time constraints.
Low dose quetiapine

100 sample patients

Total daily dose > 100mg, 46

Total daily dose ≤ 100mg, 54
Low dose quetiapine

- 12.5 mg: 1 patient
- 25 mg: 2 patients
- 50 mg: 21 patients
- 75 mg: 2 patients
- 100 mg: 28 patients
Low dose quetiapine

- Discussion on how to proceed?
Study Proposals for Upcoming Quarters:

- Multiple dosage forms of quetiapine prescribed concomitantly
Prospective DUR Report

• History Errors:
  • DD – drug-to-drug
  • PG – drug to pregnancy
  • TD – therapeutic duplication
  • ER – early refill
  • MC – drug-to-disease

• Non-History Errors:
  • PA – drug-to-age
  • HD – high dose
  • LD – low dose
  • SX – drug-to-gender
# Prospective DUR Report

**Idaho Medicaid Program**

**ProDUR Message Report**  
September 2016

<table>
<thead>
<tr>
<th>ProDUR Message</th>
<th>ProDUR Message Severity</th>
<th>Message Count</th>
<th>Message Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug To Drug</td>
<td>1</td>
<td>1,480</td>
<td>$672,218.23</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>16,582</td>
<td>$6,274,697.25</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>82,590</td>
<td>$18,961,102.83</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>3</td>
<td>$46.43</td>
</tr>
<tr>
<td>Drug To Gender</td>
<td>1</td>
<td>64</td>
<td>$25,770.58</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2,052</td>
<td>$226,913.74</td>
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<tr>
<td>Drug To Known Disease</td>
<td>1</td>
<td>66,238</td>
<td>$12,628,840.84</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>301,190</td>
<td>$77,255,061.92</td>
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<tr>
<td></td>
<td>3</td>
<td>351,561</td>
<td>$87,262,840.65</td>
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<tr>
<td>Drug To Pregnancy</td>
<td>1</td>
<td>31</td>
<td>$319.51</td>
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<tr>
<td></td>
<td>2</td>
<td>15</td>
<td>$622.01</td>
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<tr>
<td></td>
<td>A</td>
<td>2</td>
<td>$12.00</td>
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<tr>
<td></td>
<td>B</td>
<td>50</td>
<td>$14,298.51</td>
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<tr>
<td></td>
<td>C</td>
<td>94</td>
<td>$17,743.29</td>
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<td></td>
<td>D</td>
<td>14</td>
<td>$3,950.80</td>
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<td></td>
<td>X</td>
<td>4</td>
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<tr>
<td>Duplicate Therapy</td>
<td>0</td>
<td>123,135</td>
<td>$34,377,908.05</td>
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<tr>
<td>Min Max</td>
<td>0</td>
<td>26,934</td>
<td>$71,162,77.67</td>
</tr>
<tr>
<td>Too Soon Clinical</td>
<td>0</td>
<td>22,158</td>
<td>$5,460,624.57</td>
</tr>
<tr>
<td><strong>ALL</strong></td>
<td></td>
<td><strong>994,197</strong></td>
<td><strong>$250,299,335.9</strong></td>
</tr>
</tbody>
</table>

**Total Number of Claims with Messages 229,317**  
**Average ProDUR Message Per Claim 4.34**
Medicaid Update

DUR Board Meeting October 20, 2016
Idaho Medicaid Pharmacy Program

9/20/2016
Top classes contributing to spend and trend drivers

<table>
<thead>
<tr>
<th>Class</th>
<th>Total Reimbursement</th>
<th>Total Net Spend</th>
<th>% of total net Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANTIPSYCHOTICS</td>
<td>$ 9,175,490</td>
<td>$2,891,951</td>
<td>13%</td>
</tr>
<tr>
<td>STIMULANTS &amp; RELATED AGENTS</td>
<td>$ 4,317,413</td>
<td>$1,834,598</td>
<td>8%</td>
</tr>
<tr>
<td>ANTICONVULSANTS</td>
<td>$ 3,799,886</td>
<td>$1,519,805</td>
<td>7%</td>
</tr>
<tr>
<td>HEMOPHILIA TREATMENT</td>
<td>$ 1,511,613</td>
<td>$1,250,627</td>
<td>5%</td>
</tr>
<tr>
<td>HEPATITIS C AGENTS</td>
<td>$ 1,903,516</td>
<td>$836,818</td>
<td>4%</td>
</tr>
<tr>
<td>Top 5 total</td>
<td>$ 20,707,919</td>
<td>$8,333,799</td>
<td>37%</td>
</tr>
<tr>
<td>Total All</td>
<td>$ 52,836,651</td>
<td>$22,762,231</td>
<td>100%</td>
</tr>
</tbody>
</table>

Another similar state who has legislative prohibition from managing these drugs - % of total net spend is 64%

Idaho Medicaid Q1 2015 to Q1 2016
Drug Cost Management Strategies
The Idaho Medicaid net cost per claim of $40.39 is below the average of all States in the Magellan book of business at $43.46