

South Dakota Department of Social Services

Medicaid P&T Committee Meeting

September 2, 2016





DEPARTMENT OF SOCIAL SERVICES

MEDICAL SERVICES

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**SOUTH DAKOTA
MEDICAID P&T COMMITTEE MEETING
AGENDA**

September 2, 2016

1:00 – 3:00 PM

DDN Locations:

Sioux Falls

University Center

Room FADM253

4801 North Career Avenue

Pierre

Capitol Building

DDN Room A

500 E Capitol

Rapid City

SDSMT

University Relations Building

Public DDN Room

501 E Joseph St.

Call to order

Approval of minutes of previous meeting

Prior authorization update

Review of top 15 therapeutic categories/top 50 drugs

Drug spend

Old business

Review of Evzio/Narcan PA form

Opioid utilization and strategies for management

Review of gabapentin and pregabalin

Review of Xenazine

New business

OTC iron

Review of Onfi

Review of benzodiazepines

Review of Zinbryta

Review of Byvalson

Oral presentations and comments by manufacturers' representatives

Next meeting date/adjournment

**Minutes of the June 10, 2016
Pharmacy & Therapeutics (P&T) Committee Meeting
South Dakota Department of Social Services, Division of Medical
Services**

Members present

Bill Ladwig; Richard Holm; Dana Darger; Lenny Petrik; Kelley Oehlke; Deb Farver; Mikel Holland

DSS staff present

Mike Jockheck, RPh; Sara Aker, Deputy Director SD Medicaid

Administrative business

The P&T meeting was called to order by D. Darger at 1:00 p.m. The minutes of the March meeting were presented. R. Holm made a motion to approve. B. Ladwig seconded the motion. The motion was approved unanimously.

Prior authorization update and statistics

The committee reviewed the prior authorization (PA) activity for April 2016. There were a total of 3,380 PAs processed in the month of April, with 99.97% of those requests responded to in less than eight hours. There were 2,590 requests (77%) received electronically and 790 requests (23%) received by fax.

Analysis of the top 15 therapeutic classes and drug spend

The committee reviewed the top 15 therapeutic classes by total cost of claims from 01/01/2016 – 03/31/2016. The top five classes were antipsychotics, respiratory and CNS stimulants, amphetamines, insulins, and anticonvulsants, misc. The top 15 therapeutic classes make up 40.14% of total claims. The committee also reviewed the top 50 drugs based on total claims cost and number of claims. The top 50 drugs by claims cost make up 23.36% of total claims. The committee also reviewed SD Medicaid drug spend for 2013-2016. The committee asked that information regarding Onfi utilization be provided at the September meeting.

Antibiotic utilization/stewardship

Mike informed the committee that the department is working on a study regarding antibiotic utilization and the prescribers who are writing prescriptions for them. The department asked for guidance in this endeavor. The committee thought that this would be a good topic for educational letters.

Tivorbex second review

The committee reviewed the prior authorization form provided for Tivorbex. There was no public comment. K. Oehlke made a motion to approve the form. D. Farver seconded the motion. The motion was approved unanimously.

Nucala second review

The committee reviewed the prior authorization form provided for Nucala. There was no public comment. R. Holm made a motion to approve the form. M. Holland seconded the motion. The motion was approved unanimously.

Varubi second review

The committee reviewed Varubi clinical information at the March meeting and requested that more information be brought to the June meeting, including Emend utilization. There was no public comment. After review, the committee tabled the topic.

Narcan review

The committee reviewed Narcan nasal spray clinical information. There was no public comment. B. Ladwig made a motion to bring the Evzio PA form back for review (to match CDC guidelines) and to include Narcan nasal spray. D. Farver seconded the motion. The motion was approved unanimously. The form will be brought to the next meeting for review.

Zurampic review

The committee reviewed Zurampic clinical information. There was no public comment. The topic was tabled.

Livalo review

The committee reviewed Livalo clinical information. There was no public comment. The topic was tabled.

Gabapentin review

The committee reviewed gabapentin clinical information. There was no public comment. The committee requested that more information be brought back to the next meeting, including pregabalin information.

NSAID/anti-ulcer combination products review

The committee reviewed NSAID/anti-ulcer combination products clinical information. There was no public comment. The topic was tabled.

Antiprotozoal agents review

The committee reviewed antiprotozoal agents clinical information. There was no public comment. The topic was tabled.

Omega-3 fatty acids review

The committee reviewed omega-3 fatty acids clinical information. There was no public comment. The topic was tabled.

Insulin review

The committee reviewed insulin clinical information. Shawn Hanson, representing Novo Nordisk, spoke regarding Tresiba. The topic was tabled.

Xenazine review

The committee reviewed Xenazine clinical information. There was no public comment. The committee requested a prior authorization form be developed and brought back to the next meeting.

The next meeting is scheduled for September 2, 2016. B. Ladwig made a motion to adjourn the P&T Committee meeting. R. Holm seconded the motion. The motion passed unanimously and the meeting was adjourned.

**South Dakota Medicaid
Monthly Prior Authorization Report
July 1, 2016 – July 31, 2016**

Time Ratio

Total PAs	Response Under 8 Hours	Response Over 8 Hours	% Under 8 Hours	% Over 8 Hours
3,200	3,198	2	99.94%	0.06%

By Form Type

Form Type	Description	Approve	Deny
ADP	Antidepressant	157	216
AFX	Amrix and Fexmid	1	0
ALT	Altabax	0	7
AMB	Ambien CR	3	2
ANF	Anti-Infectives(anti-biotic)	1	0
ANT	Antihistamines	10	35
APS	Antipsychotic	251	331
ARB	ARBS	2	1
COA	Oral Anticoagulants	15	49
CON	Chronic Constipation Medications	8	10
DAW	Dispense As Written	5	2
GIA	Gastrointestinal Agents	0	1
GLP	GLP-1 Agonists	11	4
GRH	Growth Hormone	3	3
GSM	Genitourinary SMR	3	33
HLM	Head Lice Medication	13	4
HOR	Horizant	0	1
LID	Lidoderm	0	84
MAX	Max Units Override	55	1385
NAR	Name Brand Narcotics	4	0
NUC	Opioids	13	35
ONF	Onfi	6	1
OPH	Ophthalmic Antihistamines	1	25
PPI	Proton Pump Inhibitors	34	57
SMR	Skeletal Muscle Relaxants	0	4
STE	Nasal Steroids	7	22
STI	Stimulants	4	21
SUB	Suboxone/Subutex	10	19
TIM	Targeted Immune Modulators	11	11
TOP	Topical Acne Agents	14	57
TRP	Triptans	21	83
ULT	Ultram ER	2	0
XIF	Xifaxan	2	26
XOI	Xanthine Oxidase Inhibitor	2	2
Totals		669	2531

**South Dakota Medicaid
Monthly Prior Authorization Report
July 1, 2016 – July 31, 2016**

By Request Type

07/01/16 - 07/31/16	# of Requests	Electronic Requests		Faxed Requests	
		#	%	#	%
Prior Authorizations					
Antidepressant	373	278	75%	95	25%
Amrix and Fexmid	1	1	100%	0	0%
Altabax	7	7	100%	0	0%
Ambien CR	5	4	80%	1	20%
Anti-Infectives(anti-biotic)	1	1	100%	0	0%
Antihistamines	45	34	76%	11	24%
Antipsychotic	582	391	67%	191	33%
ARBS	3	3	100%	0	0%
Oral Anticoagulants	64	49	77%	15	23%
Chronic Constipation Medications	18	0	0%	18	100%
Dispense As Written	7	0	0%	7	100%
Gastrointestinal Agents	1	0	0%	1	100%
GLP-1 Agonists	15	0	0%	15	100%
Growth Hormone	6	3	50%	3	50%
Genitourinary SMR	36	31	86%	5	14%
Head Lice Medication	17	0	0%	17	100%
Horizant	1	1	100%	0	0%
Lidoderm	84	74	88%	10	12%
Max Units Override	1,440	1,359	94%	81	6%
Name Brand Narcotics	4	0	0%	4	100%
Opioids	48	40	83%	8	17%
Onfi	7	0	0%	7	100%
Ophthalmic Antihistamines	26	25	96%	1	4%
Proton Pump Inhibitors	91	59	65%	32	35%
Skeletal Muscle Relaxants	4	4	100%	0	0%
Nasal Steroids	29	23	79%	6	21%
Stimulants	25	17	68%	8	32%
Suboxone/Subutex	29	17	59%	12	41%
Targeted Immune Modulators	22	13	59%	9	41%
Topical Acne Agents	71	45	63%	26	37%
Triptans	104	92	88%	12	12%
Ultram ER	2	1	50%	1	50%
Xifaxan	28	24	86%	4	14%
Xanthine Oxidase Inhibitor	4	3	75%	1	25%
Prior Authorization Totals	3200	2599	81%	601	19%

**South Dakota Medicaid
Monthly Prior Authorization Report
July 1, 2016 – July 31, 2016**

Electronic PAs (unique)

07/01/16 - 07/31/16	# Unique Approved	# Unique Denied	# Unique Incomplete	Unique Total	Approval %	Total Transactions
Prior Authorizations:						
Antidepressant	89	177	0	266	33.50%	278
Amrix and Fexmid	1	0	0	1	100.00%	1
Altanax	0	7	0	7	0.00%	7
Ambien CR	2	2	0	4	50.00%	4
Anti-Infectives(anti-biotic)	1	0	0	1	100.00%	1
Antihistamines	5	27	0	32	15.60%	34
Antipsychotic	106	270	0	376	28.20%	391
ARBS	2	1	0	3	66.70%	3
Oral Anticoagulants	5	37	0	42	11.90%	49
Growth Hormone	0	1	0	1	0.00%	3
Genitourinary SMR	2	24	0	26	7.70%	31
Horizant	0	1	0	1	0.00%	1
Lidoderm	0	70	0	70	0.00%	74
Max Units Override	13	1,213	0	1,226	1.10%	1,359
Opioids	7	17	0	24	29.20%	40
Ophthalmic Antihistamines	1	24	0	25	4.00%	25
Proton Pump Inhibitors	18	33	0	51	35.30%	59
Skeletal Muscle Relaxants	0	4	0	4	0.00%	4
Nasal Steroids	6	17	0	23	26.10%	23
Stimulants	0	12	0	12	0.00%	17
Suboxone/Subutex	0	17	0	17	0.00%	17
Targeted Immune Modulators	2	11	0	13	15.40%	13
Topical Acne Agents	2	43	0	45	4.40%	45
Triptans	16	50	0	66	24.20%	92
Ultram ER	1	0	0	1	100.00%	1
Xifaxan	0	21	0	21	0.00%	24
Xanthine Oxidase Inhibitor	1	1	0	2	50.00%	3
TOTALS	280	2080	0	2360	11.90%	2599

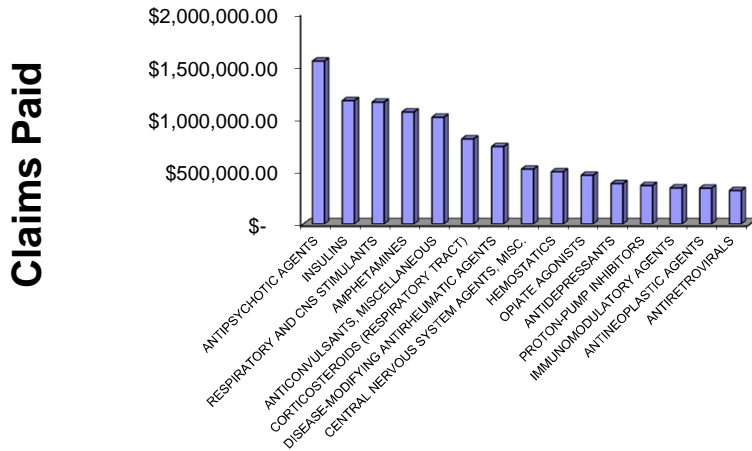
**SOUTH DAKOTA MEDICAID
Cost Management Analysis**

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 04/01/2016 - 06/30/2016

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTIPSYCHOTIC AGENTS	6,833	\$ 1,545,204.38	\$ 226.14	3.36%
INSULINS	2,548	\$ 1,170,882.08	\$ 459.53	1.25%
RESPIRATORY AND CNS STIMULANTS	6,794	\$ 1,157,340.57	\$ 170.35	3.34%
AMPHETAMINES	6,233	\$ 1,064,010.49	\$ 170.71	3.07%
ANTICONSULSANTS, MISCELLANEOUS	9,947	\$ 1,014,054.47	\$ 101.95	4.89%
CORTICOSTEROIDS (RESPIRATORY TRACT)	2,926	\$ 808,670.42	\$ 276.37	1.44%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	200	\$ 735,348.95	\$ 3,676.74	0.10%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	2,994	\$ 521,095.25	\$ 174.05	1.47%
HEMOSTATICS	23	\$ 495,426.41	\$ 21,540.28	0.01%
OPIATE AGONISTS	12,465	\$ 462,891.34	\$ 37.14	6.13%
ANTIDEPRESSANTS	19,528	\$ 383,430.46	\$ 19.63	9.61%
PROTON-PUMP INHIBITORS	6,210	\$ 365,457.92	\$ 58.85	3.05%
IMMUNOMODULATORY AGENTS	57	\$ 342,565.10	\$ 6,009.91	0.03%
ANTINEOPLASTIC AGENTS	473	\$ 341,189.90	\$ 721.33	0.23%
ANTIRETROVIRALS	222	\$ 318,193.06	\$ 1,433.30	0.11%
TOTAL TOP 15	77,453	\$ 10,725,760.80	\$ 138.48	38.10%

Total Rx Claims From 04/01/2016 - 06/30/2016	203,279
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**Top 15 Therapeutic Classes
Based on Total Cost of Claims**



**SOUTH DAKOTA MEDICAID
Cost Management Analysis**

TOP 50 DRUGS BASED ON NUMBER OF CLAIMS FROM 04/01/2016 - 06/30/2016

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
AMOXICILLIN	PENICILLINS	5,828	\$ 49,945.57	\$ 8.57	2.87%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	5,387	\$ 111,028.40	\$ 20.61	2.65%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	4,061	\$ 44,669.58	\$ 11.00	2.00%
CETIRIZINE HCL	SECOND GENERATION ANTIHISTAMINES	3,889	\$ 27,362.11	\$ 7.04	1.91%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	3,743	\$ 733,657.03	\$ 196.01	1.84%
FLUOXETINE HCL	ANTIDEPRESSANTS	3,678	\$ 41,522.03	\$ 11.29	1.81%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	3,621	\$ 67,209.42	\$ 18.56	1.78%
VYVANSE	AMPHETAMINES	3,285	\$ 769,547.27	\$ 234.26	1.62%
SERTRALINE HCL	ANTIDEPRESSANTS	3,217	\$ 23,665.90	\$ 7.36	1.58%
LEVOTHYROXINE SODIUM	THYROID AGENTS	3,113	\$ 48,200.73	\$ 15.48	1.53%
AZITHROMYCIN	MACROLIDES	2,897	\$ 50,238.54	\$ 17.34	1.43%
TRAMADOL HCL	OPIATE AGONISTS	2,715	\$ 22,318.72	\$ 8.22	1.34%
TRAZODONE HCL	ANTIDEPRESSANTS	2,697	\$ 16,773.91	\$ 6.22	1.33%
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	2,441	\$ 40,958.11	\$ 16.78	1.20%
LISINAPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	2,341	\$ 12,678.41	\$ 5.42	1.15%
LORATADINE	SECOND GENERATION ANTIHISTAMINES	2,189	\$ 12,735.18	\$ 5.82	1.08%
GUANFACINE HCL ER	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,995	\$ 49,783.82	\$ 24.95	0.98%
DEXTROAMPHETAMINE-AMPHET ER	AMPHETAMINES	1,975	\$ 233,901.54	\$ 118.43	0.97%
FLUTICASON PROPRIONATE	CORTICOSTEROIDS (EENT)	1,970	\$ 25,620.92	\$ 13.01	0.97%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	1,868	\$ 12,404.48	\$ 6.64	0.92%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	1,856	\$ 14,037.65	\$ 7.56	0.91%
ALBUTEROL SULFATE	BETA-ADRENERGIC AGONISTS	1,821	\$ 33,979.71	\$ 18.66	0.90%
VENTOLIN HFA	BETA-ADRENERGIC AGONISTS	1,799	\$ 101,152.53	\$ 56.23	0.88%
POLYETHYLENE GLYCOL 3350	CATHARTICS AND LAXATIVES	1,733	\$ 44,018.89	\$ 25.40	0.85%
SULFAMETHOXAZOLE-TRIMETHOPRIM	SULFONAMIDES (SYSTEMIC)	1,686	\$ 49,777.88	\$ 29.52	0.83%
CEPHALEXIN	CEPHALOSPORINS	1,662	\$ 25,969.14	\$ 15.63	0.82%
PROAIR HFA	BETA-ADRENERGIC AGONISTS	1,658	\$ 97,324.85	\$ 58.70	0.82%
METFORMIN HCL	BIGUANIDES	1,608	\$ 12,043.38	\$ 7.49	0.79%
VITAMIN D2	VITAMIN D	1,584	\$ 9,561.59	\$ 6.04	0.78%
AMOXICILLIN-CLAVULANATE POTASS	PENICILLINS	1,558	\$ 38,287.29	\$ 24.57	0.77%
CITALOPRAM HBR	ANTIDEPRESSANTS	1,519	\$ 9,056.24	\$ 5.96	0.75%
IBUPROFEN	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS	1,471	\$ 10,900.04	\$ 7.41	0.72%
PREDNISONE	ADRENALS	1,458	\$ 11,532.52	\$ 7.91	0.72%
CEFdinIR	CEPHALOSPORINS	1,431	\$ 50,483.71	\$ 35.28	0.70%
ARIPIRAZOLE	ANTI-PSYCHOTIC AGENTS	1,397	\$ 226,285.52	\$ 161.98	0.69%
RISPERIDONE	ANTI-PSYCHOTIC AGENTS	1,381	\$ 15,716.93	\$ 11.38	0.68%
CYCLOBENZAPRINE HCL	CENTRALLY ACTING SKELETAL MUSCLE RELAXANT	1,380	\$ 8,753.02	\$ 6.34	0.68%
LORAZEPAM	BENZODIAZEPINES (ANXIOLYTIC, SEDATIV/HYP)	1,375	\$ 8,321.47	\$ 6.05	0.68%
LAMOTRIGINE	ANTICONVULSANTS, MISCELLANEOUS	1,375	\$ 18,791.13	\$ 13.67	0.68%
QUETIAPINE FUMARATE	ANTI-PSYCHOTIC AGENTS	1,318	\$ 20,473.45	\$ 15.53	0.65%
TRIAMCINOLONE ACETONIDE	ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS)	1,270	\$ 18,007.34	\$ 14.18	0.62%
ESCITALOPRAM OXALATE	ANTIDEPRESSANTS	1,220	\$ 11,919.89	\$ 9.77	0.60%
OXYCODONE-ACETAMINOPHEN	OPIATE AGONISTS	1,210	\$ 36,855.75	\$ 30.46	0.60%
RANITIDINE HCL	HISTAMINE H2-ANTAGONISTS	1,153	\$ 9,556.93	\$ 8.29	0.57%
LEVETIRACETAM	ANTICONVULSANTS, MISCELLANEOUS	1,143	\$ 28,218.61	\$ 24.69	0.56%
VENLAFAXINE HCL ER	ANTIDEPRESSANTS	1,142	\$ 27,541.40	\$ 24.12	0.56%
DEXMETHYLPHENIDATE HCL ER	RESPIRATORY AND CNS STIMULANTS	1,126	\$ 213,305.42	\$ 189.44	0.55%
TOPIRAMATE	ANTICONVULSANTS, MISCELLANEOUS	1,116	\$ 13,074.27	\$ 11.72	0.55%
MIRTAZAPINE	ANTIDEPRESSANTS	1,095	\$ 13,807.35	\$ 12.61	0.54%
BUPROPION XL	ANTIDEPRESSANTS	1,089	\$ 26,727.61	\$ 24.54	0.54%
TOTAL TOP 50		105,544	\$ 3,599,703.18	\$ 34.11	51.92%

Total Rx Claims From 04/01/2016 - 06/30/2016	203,279
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**SOUTH DAKOTA MEDICAID
Cost Management Analysis**

TOP 50 DRUGS BASED ON TOTAL CLAIMS COST FROM 04/01/2016 - 06/30/2016

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
VYVANSE	AMPHETAMINES	3,285	\$ 769,547.27	\$ 234.26	1.62%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	3,743	\$ 733,657.03	\$ 196.01	1.84%
LATUDA	ANTIPSYCHOTIC AGENTS	444	\$ 423,188.98	\$ 953.13	0.22%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	837	\$ 349,743.80	\$ 417.85	0.41%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	901	\$ 327,722.62	\$ 363.73	0.44%
HUMIRA PEN	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	73	\$ 314,573.98	\$ 4,309.23	0.04%
ADVATE	HEMOSTATICS	5	\$ 283,546.76	\$ 56,709.35	0.00%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	166	\$ 269,311.42	\$ 1,622.36	0.08%
LANTUS SOLOSTAR	INSULINS	547	\$ 236,082.47	\$ 431.60	0.27%
DEXTROAMPHETAMINE-AMPHET ER	AMPHETAMINES	1,975	\$ 233,901.54	\$ 118.43	0.97%
NOVOLOG FLEXPEN	INSULINS	444	\$ 233,339.21	\$ 525.54	0.22%
ARIPIRAZOLE	ANTIPSYCHOTIC AGENTS	1,397	\$ 226,285.52	\$ 161.98	0.69%
ONFI	BENZODIAZEPINES (ANTICONVULSANTS)	226	\$ 22,345.28	\$ 983.83	0.11%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	617	\$ 218,077.69	\$ 353.45	0.30%
DEXMETHYLPHENIDATE HCL ER	RESPIRATORY AND CNS STIMULANTS	1,126	\$ 213,305.42	\$ 189.44	0.55%
PREVACID	PROTON-PUMP INHIBITORS	401	\$ 189,673.57	\$ 473.00	0.20%
FLOVENT HFA	CORTICOSTEROIDS (RESPIRATORY TRACT)	855	\$ 182,793.54	\$ 213.79	0.42%
PULMOZYME	MUCOLYTIC AGENTS	69	\$ 177,239.66	\$ 2,568.69	0.03%
NOVOLOG	INSULINS	426	\$ 176,999.31	\$ 415.49	0.21%
LEVEMIR FLEXTOUCH	INSULINS	312	\$ 156,115.06	\$ 500.37	0.15%
ENBREL	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	40	\$ 136,071.53	\$ 3,401.79	0.02%
SEROQUEL XR	ANTIPSYCHOTIC AGENTS	195	\$ 133,586.17	\$ 685.06	0.10%
RECOMBINATE	HEMOSTATICS	5	\$ 132,190.07	\$ 26,438.01	0.00%
TETRABENAZINE	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	17	\$ 131,722.60	\$ 7,748.39	0.01%
COPAXONE	IMMUNOMODULATORY AGENTS	23	\$ 127,165.46	\$ 5,528.93	0.01%
HUMIRA	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	29	\$ 126,918.34	\$ 4,376.49	0.01%
OXYCONTIN	OPIATE AGONISTS	329	\$ 125,965.41	\$ 382.87	0.16%
BUDESONIDE	CORTICOSTEROIDS (RESPIRATORY TRACT)	376	\$ 119,138.48	\$ 316.86	0.18%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	5,387	\$ 111,028.40	\$ 20.61	2.65%
TECFIDERA	IMMUNOMODULATORY AGENTS	17	\$ 106,629.73	\$ 6,272.34	0.01%
NORDITROPIN FLEXPRO	PITUITARY	43	\$ 105,362.90	\$ 2,450.30	0.02%
ORKAMBI	CYSTIC FIBROSIS (CFTR) POTENTIATORS	5	\$ 104,017.15	\$ 20,803.43	0.00%
LANTUS	INSULINS	243	\$ 101,741.03	\$ 418.69	0.12%
VIMPAT	ANTICONVULSANTS, MISCELLANEOUS	158	\$ 101,728.65	\$ 643.85	0.08%
VENTOLIN HFA	BETA-ADRENERGIC AGONISTS	1,799	\$ 101,152.53	\$ 56.23	0.88%
PROAIR HFA	BETA-ADRENERGIC AGONISTS	1,658	\$ 97,324.85	\$ 58.70	0.82%
GENOTROPIN	PITUITARY	29	\$ 91,947.57	\$ 3,170.61	0.01%
JANUVIA	DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	246	\$ 88,244.12	\$ 358.72	0.12%
SPIRIVA	ANTIMUSCARINICS/ANTISPASMODICS	253	\$ 86,452.31	\$ 341.71	0.12%
NUTROPIN AQ NUSPIN	PITUITARY	17	\$ 77,614.18	\$ 4,565.54	0.01%
ADVAIR HFA	CORTICOSTEROIDS (RESPIRATORY TRACT)	219	\$ 77,036.92	\$ 351.77	0.11%
BANZEL	ANTICONVULSANTS, MISCELLANEOUS	50	\$ 75,577.26	\$ 1,511.55	0.02%
GILENYA	IMMUNOMODULATORY AGENTS	11	\$ 74,769.74	\$ 6,797.25	0.01%
ALPROLIX	HEMOSTATICS	4	\$ 73,462.36	\$ 18,365.59	0.00%
STELARA	SKIN AND MUCOUS MEMBRANE AGENTS, MISC.	6	\$ 72,771.15	\$ 12,128.53	0.00%
CIPRODEX	ANTIBACTERIALS (EENT)	403	\$ 69,971.43	\$ 173.63	0.20%
XIFAXAN	ANTIBACTERIALS, MISCELLANEOUS	39	\$ 69,324.88	\$ 1,777.56	0.02%
GATTEX	GI DRUGS, MISCELLANEOUS	2	\$ 68,733.94	\$ 34,366.97	0.00%
PALIPERIDONE ER	ANTIPSYCHOTIC AGENTS	85	\$ 68,645.36	\$ 807.59	0.04%
CREON	DIGESTANTS	61	\$ 68,158.09	\$ 1,117.35	0.03%
TOTAL TOP 50		29,598	\$ 8,861,902.74	\$ 299.41	14.56%
Total Rx Claims From 04/01/2016 - 06/30/2016		203,279			

SD Medicaid Drug Spend 2013 - 2016

Drug Spend 2013

Total	201301	201302	201303	201304	201305	201306	201307	201308	201309	201310	201311	201312	Row SubTotal
Rx_Dollars	\$5,098,169.75	\$4,387,497.68	\$3,483,772.72	\$4,587,727.94	\$4,954,424.54	\$4,080,139.76	\$4,746,330.61	\$4,785,381.28	\$4,365,123.88	\$5,013,735.15	\$4,581,524.61	\$4,062,575.21	\$54,146,403.13
Rx_Count	75,726	68,046	54,790	68,602	68,081	57,928	65,533	66,327	62,205	72,336	65,859	56,582	782,015
Average_Rx_Cost	\$67.32	\$64.48	\$63.58	\$66.87	\$72.77	\$70.43	\$72.43	\$72.15	\$70.17	\$69.31	\$69.57	\$71.80	\$69.24
Recip_Count	27,719	25,992	22,293	24,675	24,016	21,412	22,581	23,564	23,754	25,749	24,485	21,798	
Recip_Average_Rx_Cost	\$183.92	\$168.80	\$156.27	\$185.93	\$206.30	\$190.55	\$210.19	\$203.08	\$183.76	\$194.72	\$187.12	\$186.37	\$187.98

Drug Spend 2014

Total	201401	201402	201403	201404	201405	201406	201407	201408	201409	201410	201411	201412	Row SubTotal
Rx_Dollars	\$5,147,300.76	\$5,032,624.29	\$5,434,147.99	\$5,247,611.60	\$5,248,010.35	\$4,405,071.19	\$4,931,375.07	\$4,738,777.48	\$4,538,235.88	\$5,773,974.96	\$5,036,186.43	\$5,931,145.84	\$61,464,461.84
Rx_Count	68,519	68,225	71,659	71,966	67,552	54,782	61,854	61,147	54,408	73,097	63,572	72,538	789,319
Average_Rx_Cost	\$75.12	\$73.77	\$75.83	\$72.92	\$77.69	\$80.41	\$79.73	\$77.50	\$83.41	\$78.99	\$79.22	\$81.77	\$77.87
Recip_Count	25,131	25,541	26,527	25,767	24,324	20,669	22,363	22,719	21,996	25,738	23,583	25,398	
Recip_Average_Rx_Cost	\$204.82	\$197.04	\$204.85	\$203.66	\$215.75	\$213.12	\$220.51	\$208.58	\$206.32	\$224.34	\$213.55	\$233.53	\$212.12

Drug Spend 2015

Total	201501	201502	201503	201504	201505	201506	201507	201508	201509	201510	201511	201512	Row SubTotal
Rx_Dollars	\$6,059,791.74	\$5,587,449.66	\$6,232,977.81	\$5,875,279.77	\$5,539,116.33	\$4,841,891.40	\$5,549,603.04	\$5,584,169.85	\$4,976,709.14	\$7,205,743.49	\$4,653,953.06	\$5,774,352.70	\$67,881,037.99
Rx_Count	75,399	70,152	77,447	74,551	67,728	57,996	68,226	66,831	58,134	89,491	54,356	72,062	832,373
Average_Rx_Cost	\$80.37	\$79.65	\$80.48	\$78.81	\$81.78	\$83.49	\$81.34	\$83.56	\$85.61	\$80.52	\$85.62	\$80.13	\$81.55
Recip_Count	27,982	26,551	28,053	26,841	24,517	21,228	23,103	23,523	22,331	25,775	21,492	25,092	
Recip_Average_Rx_Cost	\$216.56	\$210.44	\$222.19	\$218.89	\$225.93	\$228.09	\$240.21	\$237.39	\$222.86	\$279.56	\$216.54	\$230.13	\$228.95

Drug Spend 2016

Total	201601	201602	201603	201604	201605	201606	201607	201608	201609	201610	201611	201612	Row SubTotal
Rx_Dollars	\$5,918,128.79	\$3,337,591.71	\$6,418,359.83	\$5,809,485.51	\$5,797,986.95	\$5,614,028.44	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$32,895,593.02
Rx_Count	71,017	39,585	77,670	70,660	68,824	63,717	0	0	0	0	0	0	391,474
Average_Rx_Cost	\$83.33	\$84.31	\$82.64	\$82.22	\$84.24	\$88.11	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$84.03
Recip_Count	25,803	17,843	27,705	25,357	24,186	22,196	0	0	0	0	0	0	
Recip_Average_Rx_Cost	\$229.36	\$187.05	\$231.67	\$229.11	\$239.72	\$252.93	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$229.89



**EVZIO
PRIOR AUTHORIZATION**
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

**Fax Completed Form to:
866-254-0761**
For questions regarding this
Prior authorization, call
866-705-5391

SD Medicaid requires that adult patients receiving a new prescription for Evzio must meet the following criteria:

- Patient must be taking opioids (over 100 mg of morphine equivalents daily) or taking opioids with other interacting medications (benzos, muscle relaxants, etc.)

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH
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Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ()	FAX: ()

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug:	Diagnosis for this Request:	Is patient opioid dependent and/or considered high risk for opioid overdose: <input type="checkbox"/> Yes <input type="checkbox"/> No
List other interacting medications:		
PHYSICIAN SIGNATURE:		DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ():	FAX:: ()
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	



**NALOXONE RESCUE MEDICATIONS
PRIOR AUTHORIZATION**
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

<p>Fax Completed Form to: 866-254-0761 For questions regarding this Prior authorization, call 866-705-5391</p>
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SD Medicaid requires that adult patients receiving a new prescription for Evzio or Narcan nasal spray must meet the following criteria:

- Patient must be taking opioids (≥ 50 morphine milligram equivalents [MME] daily) or
- Patient must be taking opioids with other interacting medications (benzodiazepines, muscle relaxants, etc.)

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ()	FAX: ()

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: <input type="checkbox"/> EVZIO <input type="checkbox"/> NARCAN NASAL SPRAY	Diagnosis for this Request:	Is patient opioid dependent and/or considered high risk for opioid overdose: <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient taking ≥50 MME daily <input type="checkbox"/> Yes <input type="checkbox"/> No
List other interacting medications:		
PHYSICIAN SIGNATURE:	DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ():	FAX:: ()
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

CMCS Informational Bulletin

DATE: January 28, 2016

FROM: Vikki Wachino
Director
Center for Medicaid and CHIP Services

SUBJECT: Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction

The Centers for Medicare & Medicaid Services (CMS) has issued a series of Informational Bulletins on effective practices to identify and treat mental health and substance use disorders covered under Medicaid.¹ The purpose of this Bulletin is to highlight emerging Medicaid strategies for preventing opioid-related harms. The epidemic of opioid overdose, misuse and addiction is a critical public health issue that affects the lives of millions of Americans, including those who are enrolled in the Medicaid program. This Informational Bulletin provides background information on overdose deaths involving prescription opioids, describes several Medicaid pharmacy benefit management strategies for mitigating prescription drug abuse and discusses strategies to increase the provision of naloxone to reverse opioid overdose, thereby reducing opioid-related overdose deaths. Wherever possible, the bulletin provides examples of methods states can use to target the prescribing of methadone for pain relief, given the disproportionate share of opioid-related overdose deaths associated with methadone when used as a pain reliever.

Background

Opioid misuse, overdose and addiction occurs in only a subset of individuals prescribed opioid medications for pain relief. However, because many individuals take opioids, the number of Americans affected is significant. According to the Centers for Disease Control and Prevention (CDC), deaths due to prescription opioid pain medication overdose in the United States have more than quadrupled from 1999 to 2011.² Of the 43,982 drug overdose deaths in 2013, 37 percent were associated with prescription opioid analgesics (e.g., oxycodone, hydrocodone and methadone).³ A primary driver of the rapid rise in opioid overdose deaths was the increased

¹ Additional Informational Bulletins on behavioral health can be found at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html>.

² Chen LH, Hedegaard H, Warner M. Drug-poisoning deaths involving opioid analgesics: United States, 1999–2011. NCHS data brief, no 166. Hyattsville, MD: National Center for Health Statistics. 2014.

³ Hedegaard H, Chen LH, Warner M. Drug-poisoning deaths involving heroin: United States, 2000–2013. NCHS data brief, no. 190. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics. 2015. Available at <http://www.cdc.gov/nchs/data/databriefs/db190.htm>.

number of prescriptions for opioid pain medications, especially prescriptions associated with high doses, longer course of treatment and in conjunction with benzodiazepine use.^{4,5} This increased prescribing was driven by concerns about insufficient treatment of pain and lack of accurate information about the potential for addiction.⁶

In addition to the increase in drug-related deaths, the rise in opioid prescribing has led to increases in the prevalence of opioid use disorder⁷. Inappropriate opioid prescribing can also result in costly medical complications such as nonfatal overdoses, falls and fractures, drug-drug interactions and neonatal conditions. These complications result in costly, preventable healthcare expenditures and cause an incalculable amount of emotional suffering.

Combating the epidemic of opioid misuse, overdoses and addiction is the focus of a Department of Health and Human Services multipronged initiative. The initiative involves actions to improve opioid prescribing and risk mitigation strategies, increase the dissemination of overdose prevention education and expand use of naloxone (a prescription drug that reverses opioid overdoses) as well as access to substance use disorder (SUD) treatment, including medication assisted treatment for opioid use disorders.

Research shows the opioid epidemic has a disproportionate impact on Medicaid beneficiaries. Medicaid beneficiaries are prescribed painkillers at twice the rate of non-Medicaid patients and are at three-to-six times the risk of prescription painkillers overdose.^{8,9} North Carolina found that while the Medicaid population represented approximately 20 percent of the overall state population, it accounted for one-third of drug overdose deaths, the majority of which were caused by prescription opioids.¹⁰ One study from the state of Washington found that 45 percent of people who died from prescription opioid overdoses were Medicaid enrollees.¹¹

Though all prescription opioids can contribute to unintentional overdose and death, methadone in particular accounts for a disproportionate share of opioid-related overdoses and deaths. To address this, many state drug utilization review programs already incorporate utilization management criteria addressing the use of methadone. In order to reduce prescription opioid-related harms, states are encouraged to consider additional steps to reduce the use of methadone

⁴ Imtiaz S, Shield KD, Fischer B, Rehm J. Harms of prescription opioid use in the United States. *Subst Abuse Treat Prev Policy*. 2014;9:43.

⁵ Baumlatt JA, Wiedeman C, Dunn JR, Schaffner W, et al. High-risk use by patients prescribed opioids for pain and its role in overdose deaths. *JAMA Intern Med*. 2014 May; 174(5):796-801.

⁶ Meier B. A World of Hurt: Fixing Pain Medicine's Biggest Mistake. New York: New York Times e-book; 2013.

⁷ Paulozzi LJ, Jones CM, Mack KA, Rudd RA. Vital Signs: Overdoses of Prescription Opioid Pain Relievers --- United States, 1999—2008. *MMWR* 60(43); 1487-1492.

⁸ Sharp MJ, Melnik TA. Poisoning deaths involving opioid analgesics—New York State, 2003-2012. *Morb Mortal Wkly Rep* 2015; 64:377-380.

⁹ Coolen P, Lima A, Savel J, et al. Overdose deaths involving prescription opioids among Medicaid enrollees—Washington, 2004-2007. *Morb Mortal Wkly Rep*. 2009; 58:1171-1175.

¹⁰ Whitemire JT, Adams, GW. Unintentional overdose deaths in the North Carolina Medicaid population: prevalence, prescription drug use, and medical care services. *State Center for Health Studies*. August 2010(162):1-11.

¹¹ Coolen P, Lima A, Savel J, et al. Overdose deaths involving prescription opioids among Medicaid enrollees—Washington, 2004-2007. *Morb Mortal Wkly Rep*. 2009; 58:1171-1175.

prescribed for pain relief. For decades, methadone has been safely and effectively used in medication assisted treatment for opioid use disorder. Under appropriate circumstances, methadone can also be an effective pain medication.¹² However, methadone's pharmacokinetics and pharmacodynamics make it a complex medication to prescribe for pain relief.¹³ As methadone's use for pain relief has increased, so has the number of methadone related overdoses.^{14,15} While methadone represented less than 5 percent of opioid prescriptions dispensed between 2002 and 2008, it was implicated in one-third of opioid-related deaths during that time period.¹⁶ Between 2004 and 2006, the rate for methadone-related emergency department visits was approximately 23 times greater than for hydrocodone, and six times greater than for oxycodone.¹⁷ The CDC estimates that 30 percent of prescription opioid-related drug overdose deaths in 2009 involved methadone prescriptions for pain.¹⁸

The increased risk of morbidity and mortality associated with methadone is evident in the Medicaid population. Between 2006 and 2010, the rate of methadone overdose was 10 times greater than that for other prescription opioids among the Washington Medicaid population. Further, overdoses involving methadone were more than twice as fatal as overdoses involving other prescription opioids.¹⁹ Tennessee found that the risk of out-of-hospital death in non-cancer Medicaid patients receiving methadone was 46 percent greater than that for those receiving morphine.²⁰ Given the disproportionate share of opioid-related overdose deaths associated with methadone prescribed for pain relief purposes, states may consider options to reduce the use of methadone prescribed as a pain reliever as part of their efforts to reduce opioid-related harms.

Given the high impact on the program, Medicaid plays an important role in curbing the epidemic of deaths and injuries from opioid medications. Medicaid programs can encourage the use of safer, effective alternatives to opioid pain medications—in particular, alternatives to methadone prescribed for pain relief—by working collaboratively with other state agencies to educate Medicaid providers about opioid prescribing and dispensing practices. Medicaid programs can consider pharmacy benefit management strategies such as reassessing preferred drug list (PDL) placement, introducing clinical criteria, prior authorization, step therapy, quantity limits, and

¹² Chou R., et al. Methadone safety: a clinical practice guideline from the American Pain Society and College on Problems of Drug Dependence, in collaboration with the Heart Rhythm Society. *J Pain*. 2014 Apr;15(4):321-37.

¹³ U.S. Food and Drug Administration. Information for Healthcare Professionals Methadone Hydrochloride. <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm142841.htm>. Accessed September 17, 2015.

¹⁴ Ibid.

¹⁵ Ray WA, Chung CP, Murray KT, Cooper WO, Hall K, Stein CM. Out-of-hospital mortality among patients receiving methadone for noncancer pain. *JAMA Intern Med*. 2015; 175(3):420-7. doi: 10.1001/jamainternmed.2014.6294. PubMed PMID: 25599329; PubMed Central PMCID: PMC4346542.

¹⁶ Webster, L, et al. An analysis of the root causes for opioid-related overdose deaths in the United States. *Pain Medicine* 2011; 12:S26-S35.

¹⁷ Ibid.

¹⁸ Paulozzi LJ, Jones, CM, Mack KA. . Vital signs: risk for overdose from methadone used for pain relief—United States, 1999-2010. *Morb Mortal Wkly Rep*. 2012;61,493-7. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6126a5.htm>.

¹⁹ Fulton-Kehoe D, et al. Opioid poisonings in Washington state Medicaid: trends, dosing, and guidelines. *Medical Care* 2015; 53(8):679-685.

²⁰ Ray, W, et al. Out-of-hospital mortality among patients receiving methadone for noncancer pain. *JAMA Intern Med*. 2015; 175(32):420-427.

implementing drug utilization review (DUR) processes. These strategies should be revisited continually as the nature of the opioid epidemic evolves and new information emerges. States can also work to increase access to (and use of) Prescription Drug Monitoring Programs (PDMPs) to monitor opioid prescribing. Importantly, as part of a comprehensive strategy to address opioid use disorder and reduce opioid-related overdose deaths, states can consider strategies to increase the provision of naloxone and medically necessary substance use disorder treatment services. CMS initiatives and opportunities regarding substance use disorder are discussed at the end of this Bulletin.

Effective Medicaid Pharmacy Benefit Management Strategies

Opioid pain medication is one of many options to address pain relief; however, it is associated with significant risks such as sedation, cardiac arrhythmias, increased risk of falls and the development of substance use disorders.²¹ Reinforcing provider awareness about the appropriate use of opioid pain medications, as well as non-opioid analgesic options, is crucial to decreasing inappropriate opioid prescribing. Studies show limited evidence of long-term beneficial effects of long-term opioid therapy in improving chronic pain and functioning.^{22,23} In addition to patients' clinical morbidities, the risks associated with opioid use vary depending on numerous factors including the dose, type, prescribed quantity, duration of treatment and the potential for drug-drug interactions including those precipitated by the concomitant use with other central nervous system depressants or sedatives (e.g. benzodiazepines) that increase the risk of respiratory depression.²⁴ There is no formula for predicting which individuals who are prescribed opioid medications for pain will develop a substance use disorder (a dependency or addiction) or suffer an overdose. However, states can assist in minimizing these risks by implementing the following approaches:

Provider Education

States can improve opioid medication prescribing and dispensing practices by (1) supporting training for health care professionals (e.g., pharmacists, nurses, other prescribers); (2) disseminating opioid prescribing guidelines which include protocols for safer prescribing of methadone; and (3) providing clinician feedback on prescribing. These tools can highlight the importance of a complete patient assessment prior to prescribing opioid medications that would include an evaluation of the underlying etiology of pain and a screening for risk factors (e.g., substance use disorders, contraindicated medications, mental health conditions as well as parameters that could indicate higher risk for cardiac, hepatic or pulmonary adverse events like respiratory depression) that are associated with a higher probability of opioid-related harms.

²¹ Chou R, Turner JA, Devine EB, et al. The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention workshop. *Ann Intern Med.* 2015; 162:276-286.

²² Ibid.

²³ Agency for Healthcare Research and Quality. the effectiveness and risks of long-term opioid treatment of chronic pain. AHRQ Pub. No. 14-E005-1-EF <http://effectivehealthcare.ahrq.gov/ehc/products/557/1988/chronic-pain-opioid-treatment-executive-141022.pdf>. Published September 2014. Accessed September 17, 2015.

²⁴ Roxane Laboratories, Inc. Dolophine® Hydrochloride CII (Methadone Hydrochloride Tablets, USP). http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/006134s0281bl.pdf. Accessed September 17, 2015.

These tools should also emphasize the need for ongoing patient monitoring. Educational materials can offer guidance on the decision to initiate opioid pain medications and, if appropriate, which type of medication to initiate. For instance, methadone, which is characterized by complicated and variable pharmacokinetics and pharmacodynamics, should be initiated and titrated cautiously only by clinicians who are familiar with its use and risks.²⁵ Recent guidelines provide monitoring recommendations for prescribing methadone to specific patients.²⁶

Several state Medicaid agencies have been part of collaborative efforts to educate providers about opioid medication prescribing. For example, Washington State developed an opioid prescribing guideline in 2007 which has since been updated that uses an interagency state work group in collaboration with clinical experts.²⁷ As part of a comprehensive effort, overdose deaths and hospitalizations for prescription opioids in Washington have declined in recent years.²⁸

Preferred Drug List

Medications are often designated as preferred or non-preferred drugs by the pharmacy and therapeutics committee (P&T) or DUR board of the state Medicaid agencies or contracted managed care organization. In most cases, providers are permitted to prescribe preferred drugs without seeking prior authorization. However, if a drug is listed as non-preferred on the PDL, the providers are usually required to obtain approval from the state Medicaid agency or managed care plan before the drug is paid for. States may subject a drug to such prior authorization consistent with the requirements of section 1927(d)(5) of the Act.

Given the significant evidence suggesting that the use of methadone contributes disproportionately to opioid overdose and deaths, the known complexities with appropriately prescribing this medication as well as the widespread availability of other medications to treat pain, we urge that states remove methadone for pain (outside of end of life care) from their preferred drug lists. This is consistent with the recommendation from the CDC that methadone should not be considered a drug of first choice by prescribers or insurers for chronic non-cancer pain.²⁹ States that provide a prescription drug benefit will still have to make the drug available to Medicaid patients who need it, as long as it is a covered outpatient drug. By removing the drug from preferred status, states have the option of limiting its use to only those patients for whom treatment with other pain medications is ineffective.

²⁵ Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain*. 2009;10(2):113-130.e22.

²⁶ Chou R, Cruciani RA, Fiellin DA, et al. Methadone safety: a clinical practice guideline from the American Pain Society and College on problems of drug dependence, in collaboration with the Heart Rhythm Society. *J Pain*. 2014; 15(4):321-337.

²⁷ Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain, 3rd edition. <http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>. Published June 2015. Accessed September 17, 2015.

²⁸ Franklin G, Sabel J, Jones CM, et al. A comprehensive approach to address the prescription opioid epidemic in Washington State: milestones and lessons learned. *Am J Public Health*. 2015 Mar; 105(3):463-9. doi: 10.2105/AJPH.2014.302367. Epub 2015 Jan 20.

²⁹ Paulozzi LJ, Jones, CM, Mack KA. . Vital signs: risk for overdose from methadone used for pain relief—United States, 1999-2010. *Morb Mortal Wkly Rep*. 2012;61,493-7. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6126a5.htm>.

Clinical Criteria

States may decide that methadone should remain a preferred drug while requiring edits that allow claims to be authorized for payment at the point-of-sale (POS) only when the recipients' claims and/or diagnosis history satisfy each of the clinical criteria established to ensure appropriate utilization of the drug. For example, when states process methadone claims, the automated review of the recipients' claim histories could confirm the presence or absence of any recent claims for benzodiazepines or long-acting opioids within a specified time period. The concomitant use of methadone with these medications could be precluded due to drug-drug interactions that increase the recipients' risk of respiratory depression and opioid overdose. Additionally, before methadone claims are paid, the automated review could ascertain chronic pain diagnosis in the recipients' diagnosis histories. When methadone claims do not satisfy these clinical criteria, payment would not be immediately authorized at the POS. Instead, the claims would be subject to the prior authorization process consistent with the requirements of the Act, which would require the provider to obtain approval from the state Medicaid agency or contracted managed care organization.

Step Therapy

A Medicaid program may require the trial of another agent prior to the use of a specific drug. For example, a state that has methadone on its PDL may require that, before authorizing payment, an examination of the recipient's claims history is performed to ensure that the recipient used another preferred, long-acting opioid for a specified duration before beginning methadone therapy.

The state of Vermont implemented prior authorization criteria which involves step therapy for methadone recently. Among other criteria, this state has a requirement that before initially being prescribed methadone for pain, patients must have documented side effects, allergies, or treatment failure to a preferred, long-acting opioid.

Prior Authorization

Prior authorization typically means that the Medicaid agency or the contracted managed care organization will not pay for Medicaid beneficiaries' medication unless the provider has obtained permission before prescribing the drug. The criteria for prior authorization often reflect evidence-based standards consistent with the compendia listed in 1927(g)(1)(B). For example, prior authorization can help ensure that prescriptions for pain in doses higher than 30 milligrams of methadone per day (the recommended maximum daily starting dose) are appropriate.

Virginia's Medicaid program is one of 19 states with prior authorization criteria for long-acting opioid pain medication. Before long-acting opioids can be approved for managing chronic, nonmalignant pain, providers must (1) document that there is treatment plan that includes a diagnosis, the goals of therapy as well as an assessment of addiction risk; and (2) attest that the Virginia Board of Pharmacy PDMP database has been recently reviewed. Patients must sign a pain management contract that addresses the consequences of unexplained loss or shortage of

medications as well as those associated with obtaining similar prescription medications from other prescribers. Patients must also sign an agreement to use only one pharmacy further described below in patient review and restriction programs.

Quantity Limits

A state Medicaid agency or contracted managed care organization may impose quantity limits on medications as a way to promote safe and appropriate use of a medication, ensuring that they are not overprescribed. For example, quantity limits may be useful in verifying that a methadone prescription for pain is prescribed only for a specified duration, so the prescriber can reassess the recipient periodically. A significant percentage of states apply quantity limits to opioid products prescribed for pain.

Drug Utilization Review

Retrospective and concurrent drug utilization review (DUR) measures can be used to identify potentially inappropriate prescribing practices. States are encouraged to exercise sound clinical judgment and utilize available resources to aid their DUR programs and P&T committees. We note the availability of the Pharmacy Quality Alliance's three measures of potential opioid misuse and abuse. These measures include receiving opioids (1) at high dosage, (2) from multiple prescribers and pharmacies, and (3) at high dosage and from multiple prescribers and pharmacies.³⁰ In order to optimize care while discouraging fraud, waste and abuse of prescribed opioids, states are encouraged to consider implementing programs that provide ancillary care for beneficiaries diagnosed with chronic pain who have been found to be receiving unusually high doses of opioids, seeing multiple prescribers or pharmacies.

Increase Access to and Use of State Prescription Drug Monitoring Programs

PDMPs collect data from pharmacies, outpatient hospital pharmacies, outpatient clinics and other data submitters on dispensed, controlled substance prescriptions. To oversee its PDMP, each state designates an agency which may include, but is not limited to health departments, pharmacy boards or a state law enforcement agency. Additionally, each state controls who will have access to the database and for what purpose. Authorized users can obtain these data through a secure and electronically-accessible database. PDMPs have been shown to be effective in preventing drug diversion.

CMS understands that many Medicaid agencies have reported barriers that hinder their ability to utilize the PDMP database in their state. These barriers include lack of funding to maintain operation of the PDMP, prescribers not accessing the database to obtain patient history, lag time in submission of prescription data to the database, administrative limitations denying real-time access and restrictions limiting Medicaid agency access to the database. Reasons for limiting Medicaid agency access to PDMPs include state laws prohibiting Medicaid agency access, Medicaid pharmacy staff being denied access because they are not directly delivering healthcare, database access being limited to law enforcement members or access allowed only for active

³⁰ Pharmacy Quality Alliance. PQA Measure Development. 2015. <http://pqaalliance.org/measures/default.asp>. Accessed September 17, 2015.

investigations. In addition, some states allow patients to opt out of having their prescriptions entered into the database. However, despite these barriers, some states allow Medicaid programs to access PDMP data so they can better identify potential inappropriate prescribing and use of controlled prescription drugs, such as opioids, and some Medicaid agencies require prescribers and pharmacies to access patient history in the PDMP database prior to prescribing and dispensing controlled substances, thereby enhancing states' DUR program oversight activities. There are several strategies states can pursue to increase PDMP adoption and functionality. For example, in states where Medicaid can access PDMP information, state Medicaid programs can consider including language into provider agreements and managed care contracts to require providers to access their state PDMP as a condition of provider agreement and payment, to the extent that such access is permissible under applicable Federal and state laws. Further, states can harness the benefits of their PDMP use by requiring mandatory electronic prescribing of controlled substances if consistent with applicable Federal and state laws. To enhance functionality, states could develop real-time data infrastructure between pharmacy POS systems and PDMPs to capture cash transactions. This would enable PDMP users to determine if beneficiaries are filling opioid prescriptions outside of the Medicaid benefit and/or are using multiple pharmacies. Such programs would be subject to applicable Federal laws as well as state privacy laws. In states where the Medicaid agency has limited access to the PDMP, state Medicaid directors could advocate directly with State Boards of Pharmacy and state legislators to promote access. Successful collaborative initiatives to reduce prescription opioid abuse in Oklahoma and Washington included promoting full access to PDMP data for monitoring and data research purposes.^{31,32}

In 2013, New York required prescribers to check the state's PDMP before prescribing opioid pain medications. Since 2013, they reported a 75 percent drop in the number of patients who used multiple prescribers and pharmacies for controlled prescription drugs.³³ In concert with related policies targeting inappropriate opioid prescribing, Florida found that oxycodone-caused mortality declined 25 percent in the month immediately following implementation of Florida's PDMP.³⁴ Other states showed a decrease in controlled substance prescriptions and patients visiting multiple practitioners seeking opioid pain medications. In addition, states were able to identify patients in need of addiction or pain management support. Improvements in prescribing behaviors and decreases in adverse effects are expected to be even greater when the PDMP is part of a health information technology system. PDMPs are most effective when they are used by all clinicians, don't interfere with access to medicine for legitimate medical needs and protect sensitive personal and health information.³⁵

³¹ State Medicaid interventions for preventing prescription drug abuse and overdose: a report for the National Association of Medicaid Directors. October 1, 2014. Available at: <http://medicaiddirectors.org/node/1071>.

³² A state plan: reducing prescription drug abuse in Oklahoma. 2013. Available at: <http://www.ok.gov/odmhasas/documents/Rx%20Abuse%20Prevention%20Plan.pdf>.

³³ PDMP Center of Excellence at Brandeis University. Mandating PDMP participation by medical providers: current status and experience in selected states. 2014. <http://www.pdmpexcellence.org/content/mandating-medical-provider-participation-pdmps>. Accessed on September 17, 2015.

³⁴ Delcher C, Wagenaar AC, Goldberger BA, Cook RL, Maldonado-Molina MM. Abrupt decline in oxycodone-caused mortality after implementation of Florida's Prescription Drug Monitoring Program. *Drug Alcohol Depend.* 2015; 150:63-8. doi: 10.1016/j.drugalcdep.2015.02.010. Epub 2015 Feb 19.

³⁵ Islam MM, McRae IS. An inevitable wave of prescription drug monitoring programs in the context of prescription opioids: pros, cons and tensions. *BMC Pharmacol Toxicol.* 2014;15:46.

Patient Review and Restriction Programs

Most Medicaid programs have implemented Patient Review and Restriction programs (PRRs) to address possible patient overuse of opioid medications and other controlled prescription drugs. If a Medicaid agency finds that beneficiaries have used Medicaid services at a frequency or an amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state, the agency may restrict those beneficiaries to obtain Medicaid services from designated providers for a reasonable period of time. Medicaid programs can only impose these restrictions if they (1) give patients notice and an opportunity for a hearing, (2) ensure that restricted patients still have reasonable access to Medicaid services, and (3) exclude emergency services from the restriction as described in 42 CFR 431.54(e). A number of state Medicaid programs including Louisiana, Washington, Oklahoma, Connecticut, Iowa, and North Carolina report that their PRRs have resulted in fewer narcotic analgesic pills prescribed and cost savings.³⁶

While states may consider the aforementioned approaches to reduce the risk of prescription opioid-related harm, states should develop policies and strategies that are consistent with the Mental Health Parity and Addiction Equity Act which seeks to ensure that financial and treatment limitations for mental health and substance use disorders are applied no more restrictively than medical/surgical benefits.³⁷ This includes the use of prior authorization, step therapy and quantity limits which may be seen as treatment limitations that would be inconsistent with the application of the Mental Health Parity and Addiction Equity Act to the Medicaid program. CMS is available to provide technical assistance on these points.

Increasing the Use of Naloxone to Reverse Opioid Overdose

In addition to the pharmacy benefit management and monitoring strategies described above, states can also work to increase the provision of naloxone to reverse drug overdoses and reduce the number of opioid-related overdose deaths.

Naloxone is a drug indicated for the complete or partial reversal of narcotic depression, including respiratory depression induced by opioids including natural and synthetic narcotics, propoxyphene, methadone and certain narcotic-antagonist analgesics. It is also indicated for the diagnosis of suspected acute opioid overdose.³⁸ Naloxone prevents or reverses the potential life-threatening effects of opioids, including respiratory depression, sedation, and hypotension, thereby allowing an opioid overdose victim to resume normal breathing. Naloxone has not been

³⁶ Roberts AW, Skinner AC. Assessing the present state and potential of Medicaid controlled substance lock-in programs. *J Manag Care Spec Pharm.* 2014;20:439-46c.

³⁷ See CMS State Health Official Letter # 13-001. Re: Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans. Available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.

³⁸ Naloxone hydrochloride FDA-approved drug label Information. Obtained from <http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=76f7eee1-d524-43a4-a868-ffa9f29638a6>.

shown to produce tolerance or to cause physical or psychological dependence^{39,40} and is not designated as a controlled substance by the Drug Enforcement Agency. In the absence of opioids or agonistic effects of other opioid antagonists, naloxone exhibits essentially no pharmacologic activity. However, in cases of opioid overdose emergency, naloxone is most effective with rapid onset of action and this requires it to be administered in a timely manner.⁴¹

In most states, naloxone is not available as an over-the-counter drug. Instead, it can be provided by prescription during the regular course of medical care. Depending on a state's laws, this medication can be provided by pharmacist-initiated collaborative practice agreements, pharmacist prescriptive authority, state authorizing legislation (which protects physicians who prescribe and citizens who administer take-home naloxone), or community-based overdose education and naloxone distribution programs.

To promote ease of access to this potentially life-saving treatment, some communities distribute naloxone kits (that may contain naloxone and syringes fitted with an atomizer for easier nasal administration as opposed to intravenously) and often provide training on the proper use of these products. The first FDA-approved naloxone nasal spray was approved in November of 2015. State Medicaid agencies vary in their coverage of take-home naloxone and the atomizer (i.e., a pump-driven device that sprays injectable naloxone into the nose) for its administration. Some states cover the cost of the drug only after preapproval or prior authorization on the basis of medical necessity. Some only cover the cost of the drug and not the atomizer. Others cover the cost of the drug (with or without the atomizer) only for selected Medicaid populations (e.g., individuals enrolled in managed care, fee-for-service, or an alternative benefit plan).⁴² For example, New Mexico's Medicaid program reimburses for naloxone rescue kits for beneficiaries at risk for opioid overdose.⁴³

State Medicaid programs, in coordination with other state organizations, have taken the following strategies to improve access to naloxone:

Include Naloxone on the Medicaid Preferred Drug List

Medicaid programs in a number of states such as California and New York include all injectable forms of naloxone including the auto-injectable form of naloxone on their Medicaid Preferred Drug Lists. States that provide a prescription drug benefit are reminded that the Fee-for-Service program and the managed care organization contractors must provide coverage for drugs that are

³⁹ Naloxone hydrochloride FDA-approved drug label Information. Obtained from

<http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=76f7eee1-d524-43a4-a868-ffa9f29638a6>

⁴⁰ Kim D, Irwin K, Khoshnood K. Am J Public Health. 2009 March; 99(3): 402–407. Expanded Access to Naloxone: Options for Critical Response to the Epidemic of Opioid Overdose Mortality.

⁴¹ Naloxone hydrochloride FDA-approved drug label Information. Obtained from

<http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=76f7eee1-d524-43a4-a868-ffa9f29638a6>.

⁴² Seiler N, Horton K, Malcarney M-B. Medicaid reimbursement for take-home naloxone: a toolkit for advocates. Milken Institute School of Public Health, The George Washington University. 2014.

http://publichealth.gwu.edu/pdf/hp/naloxone_medicaid_report_gwu.pdf.

⁴³ New Mexico Department of Health. Coverage of naloxone under Medicaid announced: expansion of toolkit to help reduce overdose deaths. <http://nmhealth.org/news/information/2014/6/?view=88>. Published June 18, 2014.

Accessed September 17, 2015.

covered outpatient drugs (that is, drugs from manufacturers that have entered into, and have in effect, rebate agreements described in section 1927(b) of the Act, unless specifically excluded from coverage by statute), such as the auto-injectable and intranasal formulations of naloxone, whether or not they are included on their Preferred Drug Lists.

Expand Community-Based Naloxone Distribution Programs

Providing naloxone kits to laypeople reduces overdose deaths while being safe and cost effective.^{44,45,46} U.S. and international health organizations recommend providing naloxone kits to patients in substance use treatment programs, individuals leaving prison and jail and laypeople who might witness an opioid overdose.⁴⁷ As of 2014, the [CDC](#) reported that naloxone distributed to laypeople had resulted in more than 26,000 overdose reversals nationwide since 1996.⁴⁸ Since 2006, [Massachusetts has implemented an overdose education and naloxone distribution program](#) that significantly reduced overdose deaths in the 19 communities.⁴⁹

Expand Access to Naloxone by Making It Available Without a Prescription

On July 16, 2015, Ohio's governor enacted emergency legislation that makes naloxone available without a prescription in the state. With this policy change, pharmacies can now offer naloxone over the counter to individuals cleared by a doctor or health official. Kentucky also enacted a similar approach in 2015 that allowed first responders or members of an opioid user's family to receive naloxone without a prescription.

Offer Training in Overdose Prevention and Response

States such as Rhode Island are expanding the training that they provide for overdose prevention and response. To reduce overdose deaths, this training is being offered to opioid users, their families and friends, addiction treatment program staff, community coalitions, human services providers, correctional staff, first responders, prescribers, and pharmacists.

State Laws That Have Been Enacted To Address Liability Concerns Related to Naloxone

A number of states have passed laws that address both bystander and physician concerns regarding the distribution and administration of take-home naloxone. These laws generally provide legal protection to the physicians who prescribe and to the bystanders ("Good

⁴⁴ Doyon S, Aks SE, Schaeffer S. Expanding access to naloxone in the United States. *Clin Toxicol*. 2014;52:989-992.

⁴⁵ Walley A, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ*. 2013;346:1-12.

⁴⁶ Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Ann Intern Med*. 2013;158:1-9.

⁴⁷ Opioid overdose prevention programs providing naloxone to laypersons—United States, 2014. *Morb Mortal Wkly Rep*. 2015;64:631-635.

⁴⁸ Opioid overdose prevention programs providing naloxone to laypersons—United States, 2014. *Morb Mortal Wkly Rep*. 2015;64:631-635.

⁴⁹ Walley A. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ*. 2013;346:f174.

Samaritans”) who possess or administer take-home naloxone. For example, state laws may provide immunity from civil or criminal liability by waiving criminal liability for possession of naloxone without a prescription, laypersons’ administration of naloxone, or authorizing prescriptions to third parties other than those at risk of overdose.

Expanding Coverage and Access to Opioid Use Disorder Treatment

As part of a comprehensive strategy to address opioid use disorder, states can assess their Medicaid benefits coverage, delivery systems, payment mechanisms and provider networks for substance use disorder services to ensure that effective treatments are available to beneficiaries when medically appropriate. This Informational Bulletin is the latest in a series of actions CMS has taken to support state efforts to effectively design, deliver and pay for services to treat substance use disorder. CMS is available to assist states in determining how to incorporate additional services and providers into their Medicaid programs, as we believe ensuring access to a robust set of treatment models is critical to combatting opioid use disorder and its healthcare complications.

In July 2014, CMS launched the Medicaid Innovation Accelerator Program (IAP), a strategic support platform designed to support states' ongoing delivery system reforms.⁵⁰ Based on our work with states and stakeholders, CMS identified substance use disorder as the first focus area for IAP efforts. The IAP provides states with expert resources, coaching opportunities and hands-on program support to accelerate policy, program and payment reforms appropriate for a robust SUD system. The goal of the IAP initiative on SUD is to support participating states to better identify individuals with SUD, enhance provider capacity to effectively treat individuals with SUD, and expand coverage for promising and evidence-based SUD services, such as medication-assisted treatment.

CMS also recently issued several Informational Bulletins regarding Medicaid coverage for behavioral health conditions, including a joint publication with the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, and the National Institute on Drug Abuse describing best practices, state-based initiatives and useful resources for the delivery of medication-assisted treatment.⁵¹ In January 2015, CMS released an Informational Bulletin addressing early identification and treatment of adolescents with a SUD.⁵² Earlier this year, CMS also proposed several rules that, if finalized, would strengthen states’ ability to provide services to individuals with substance use disorder. In April 2015, CMS issued a proposed rule that would offer the protections of the Mental Health Parity and Addiction Equity Act to any beneficiary enrolled in a Medicaid or CHIP managed care organization. CMS is currently considering comments on the rule. In May 2015, CMS proposed a rule that would allow states to claim federal funds for managed care beneficiaries who receive crisis stabilization treatment in inpatient and sub-acute crisis facilities. This provision of the proposed managed care rule is designed to improve access to medically necessary short-term inpatient behavioral health services.

⁵⁰ For more information, please visit <http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/innovation-accelerator-program.html>.

⁵¹ <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>.

⁵² <http://medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf>.

CMS recognizes the need to improve access to non-hospital based services as well. In July 2015, CMS issued guidance on a new opportunity under section 1115 demonstration authority to develop a full continuum of care for individuals with a SUD, including coverage for short-term residential treatment services not otherwise covered by Medicaid.⁵³ This new opportunity is geared to support states engaged in broad and deep SUD system transformation efforts, enabling them to provide a full continuum of care by introducing service, payment and delivery system reforms to improve the care for individuals with SUD.

Our efforts directly support the Department of Health and Human Services initiative on opioid abuse and the recent Presidential Memorandum addressing prescription drug abuse and heroin use. In March 2015, Secretary Burwell launched a multi-pronged initiative to decrease opioid overdoses, overdose mortality and the prevalence of opioid use disorder.⁵⁴ The Secretary's initiative targets three priority areas: opioid prescribing practices; expanded use and distribution of naloxone; and expansion of medication-assisted treatment (MAT). In October 2015, President Obama issued a memorandum with the goals of reducing prescription opioid and heroin deaths, promoting appropriate and effective pain medication prescribing and improving access to treatment.⁵⁵ The President's memorandum directs certain federal departments and agencies to take several actions, including training federal health care prescribers on the appropriate and effective prescribing of opioid pain medications, reviewing health benefit requirements and policies in order to identify any barriers individuals with opioid use disorder would encounter in accessing MAT, and identifying any current practices, such as the use of methadone as a preferred or first-line pain management drug that are inconsistent with the goals of reducing opioid use disorders and overdoses. This bulletin is part of CMS' ongoing effort to support these initiatives.

In addition to considering the pharmacy benefit management strategies described in this bulletin to mitigate the risk of prescription opioid-related harm, states may consider reviewing their benefits coverage, service utilization and other data to assess if Medicaid enrollees with opioid use disorder have sufficient access to MAT services. MAT is the use of FDA-approved medications in combination with behavioral therapies to provide a whole-patient approach to treating SUDs.⁵⁶ There is strong evidence that the use of MAT provides substantial cost savings and leads to improved quality of life and health outcomes for individuals with SUD, including opioid use disorder.⁵⁷ Buprenorphine, methadone and naltrexone are the three medications approved by the FDA for opioid dependence. Studies have shown that the most effective treatments for opioid use disorders are those that include a set of comprehensive medical, social,

⁵³ <http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>.

⁵⁴ <https://aspe.hhs.gov/basic-report/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths>.

⁵⁵ <https://www.whitehouse.gov/the-press-office/2015/10/21/presidential-memorandum-addressing-prescription-drug-abuse-and-heroin>.

⁵⁶ <https://aspe.hhs.gov/basic-report/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths>.

⁵⁷ <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>.

psychological and rehabilitation services that address all the needs of the individual.⁵⁸

Although MAT has significant evidence to support it as an effective treatment, it remains highly underutilized. Many Medicaid programs use benefit design requirements, such as prior authorization, that may reduce the use of and access to MAT. For example, as of 2013 prior authorization was required for the use of buprenorphine-naloxone in 48 Medicaid programs. A number of states also have total lifetime limits on the use of buprenorphine-naloxone, even though the scientific literature shows that opioid use disorder is a chronic disease.⁵⁹ CMS is committed to assisting states in addressing opioid use disorder and providing effective treatment services for individuals with substance use disorder. CMS is available to provide technical support to states assessing access to MAT services for individuals with opioid use disorder.

⁵⁸ Potter, J.S.; Marino, E.N.; Hillhouse, M.P., et al. Buprenorphine/naloxone and methadone maintenance treatment outcomes for opioid analgesic, heroin, and combined users: findings from Starting Treatment with Agonist Replacement Therapies (START). *Journal of Studies on Alcohol and Drugs* 74(4):605-613, 2013.

⁵⁹ Substance Abuse and Mental Health Services Administration. Medicaid coverage and financing of medications to treat alcohol and opioid use disorders. HHS Publication No. SMA-14-4854. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Resources

Substance Abuse and Mental Health Services Administration. Opioid overdose prevention toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014. Available at <http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-474>

U.S. National Library of Medicine. MedLine Plus. Prescription Drug Abuse. <https://www.nlm.nih.gov/medlineplus/prescriptiondrugabuse.html>

U.S. National Library of Medicine. MedLine Plus. Pain Relievers. <https://www.nlm.nih.gov/medlineplus/painrelievers.html>

Medicare Part D Opioid Drug Mapping Tool. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap.html>

Additional information about the Centers for Medicare & Medicaid Services Medicare Part D opioid over utilization policy is available at: <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html>

Additional information about Recent Medicaid Prescription Drug Laws and Strategies is available on the National Alliance for Model State Drug Laws is available at: <http://www.namsdl.org/>

Additional information about State Medicaid interventions for preventing prescription drug abuse and overdose is available in the following document: *Interventions For Preventing Prescription Drug Abuse And Overdose: A Report For The National Association Of Medicaid Directors. October 1, 2014.* Available at: http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_rx_abuse_report_october_2014.pdf

Additional information about Prescription Drug Monitoring Programs (PDMP) Center of Excellence is available at: <http://www.pdmpexcellence.org/>

Additional information about the Washington State Agency Medical Directors Group's continuing medical education concerning opioid prescribing is available at: <http://www.agencymeddirectors.wa.gov/quality.asp>

SD Medicaid Opioid Utilization (AHFS 280808)

07/01/15 - 06/30/16

Label Name	Rx Num	Total Reimb Amt	Avg Cost per Script
ACETAMINOP-CODEINE 120-12 MG/5	472	\$3,106.00	\$6.58
ACETAMINOPHEN-COD #2 TABLET	8	\$59.24	\$7.41
ACETAMINOPHEN-COD #3 TABLET	1,605	\$14,400.54	\$8.97
ACETAMINOPHEN-COD #4 TABLET	25	\$524.27	\$20.97
ASCOMP WITH CODEINE CAPSULE	8	\$229.87	\$28.73
BELLADONNA-OPIUM 16.2-30 SUPP	2	\$329.56	\$164.78
BELLADONNA-OPIUM 16.2-60 SUPP	1	\$1,680.75	\$1,680.75
BUTALB-ACETAMINOPH-CAFF-CODEIN	10	\$1,736.94	\$173.69
BUTALB-CAFF-ACETAMINOPH-CODEIN	48	\$931.25	\$19.40
BUTALBITAL COMP-CODEINE #3 CAP	25	\$3,146.99	\$125.88
CODEINE SULFATE 15 MG TABLET	1	\$5.36	\$5.36
CODEINE SULFATE 30 MG TABLET	6	\$158.27	\$26.38
DEMEROL 100 MG/ML SYRINGE	1	\$6.61	\$6.61
ENDOCET 10-325 MG TABLET	33	\$2,338.47	\$70.86
ENDOCET 2.5-325 MG TABLET	1	\$110.36	\$110.36
ENDOCET 5-325 TABLET	12	\$146.76	\$12.23
ENDOCET 7.5-325 MG TABLET	2	\$123.35	\$61.68
FENTANYL 100 MCG/HR PATCH	213	\$23,278.76	\$109.29
FENTANYL 12 MCG/HR PATCH	186	\$22,859.17	\$122.90
FENTANYL 25 MCG/HR PATCH	315	\$13,069.60	\$41.49
FENTANYL 37.5 MCG/HR PATCH	1	\$444.32	\$444.32
FENTANYL 50 MCG/HR PATCH	386	\$24,313.12	\$62.99
FENTANYL 75 MCG/HR PATCH	180	\$13,576.30	\$75.42
HYDROCODON-ACETAMIN 7.5-325/15	1,330	\$74,683.73	\$56.15
HYDROCODON-ACETAMINOPH 2.5-325	2	\$63.39	\$31.70
HYDROCODON-ACETAMINOPH 7.5-300	5	\$290.62	\$58.12
HYDROCODON-ACETAMINOPH 7.5-325	1,773	\$46,144.40	\$26.03
HYDROCODON-ACETAMINOPHEN 5-300	35	\$1,184.10	\$33.83
HYDROCODON-ACETAMINOPHEN 5-325	14,410	\$222,475.09	\$15.44
HYDROCODON-ACETAMINOPHN 10-300	33	\$7,691.99	\$233.09
HYDROCODON-ACETAMINOPHN 10-325	4,344	\$146,747.81	\$33.78
HYDROCODONE-IBUPROFEN 5-200 MG	7	\$837.29	\$119.61
HYDROCODONE-IBUPROFEN 7.5-200	311	\$4,194.75	\$13.49
HYDROMORPHONE 1 MG/ML SOLUTION	2	\$100.30	\$50.15
HYDROMORPHONE 1 MG/ML SYRINGE	1	\$7.58	\$7.58
HYDROMORPHONE 2 MG TABLET	228	\$2,549.98	\$11.18
HYDROMORPHONE 4 MG TABLET	188	\$2,724.87	\$14.49
HYDROMORPHONE 5 MG/5 ML SOLN	2	\$13.72	\$6.86
HYDROMORPHONE 8 MG TABLET	15	\$536.30	\$35.75
HYDROMORPHONE HCL ER 12 MG TAB	1	\$222.26	\$222.26
HYDROMORPHONE HCL ER 16 MG TAB	1	\$626.41	\$626.41
HYSINGLA ER 20 MG TABLET	11	\$2,213.70	\$201.25
HYSINGLA ER 30 MG TABLET	25	\$6,365.93	\$254.64
HYSINGLA ER 40 MG TABLET	8	\$3,322.88	\$415.36

SD Medicaid Opioid Utilization (AHFS 280808)

07/01/15 - 06/30/16

Label Name	Rx Num	Total Reimb Amt	Avg Cost per Script
HYSINGLA ER 60 MG TABLET	4	\$2,352.10	\$588.03
LORTAB 10 MG-300 MG/15 ML ELXR	18	\$1,399.14	\$77.73
MEPERIDINE 50 MG TABLET	26	\$274.90	\$10.57
METHADONE 10 MG/5 ML SOLUTION	2	\$98.47	\$49.24
METHADONE 5 MG/5 ML SOLUTION	7	\$62.32	\$8.90
METHADONE HCL 10 MG TABLET	190	\$3,713.75	\$19.55
METHADONE HCL 5 MG TABLET	99	\$1,191.38	\$12.03
MORPHINE 2 MG/ML CARPUJECT	4	\$36.70	\$9.18
MORPHINE SULF 10 MG/5 ML SOLN	3	\$44.97	\$14.99
MORPHINE SULF 100 MG/5 ML SOLN	49	\$2,010.16	\$41.02
MORPHINE SULF ER 100 MG TABLET	54	\$9,456.42	\$175.12
MORPHINE SULF ER 15 MG TABLET	366	\$13,002.96	\$35.53
MORPHINE SULF ER 30 MG TABLET	383	\$27,531.91	\$71.88
MORPHINE SULF ER 60 MG TABLET	128	\$15,496.14	\$121.06
MORPHINE SULFATE ER 10 MG CAP	3	\$256.91	\$85.64
MORPHINE SULFATE ER 100 MG CAP	1	\$480.65	\$480.65
MORPHINE SULFATE ER 20 MG CAP	15	\$3,878.16	\$258.54
MORPHINE SULFATE ER 60 MG CAP	3	\$1,626.52	\$542.17
MORPHINE SULFATE IR 15 MG TAB	264	\$4,079.26	\$15.45
MORPHINE SULFATE IR 30 MG TAB	151	\$2,619.95	\$17.35
NUCYNTA 100 MG TABLET	65	\$32,562.17	\$500.96
NUCYNTA 50 MG TABLET	45	\$11,723.52	\$260.52
NUCYNTA 75 MG TABLET	16	\$8,725.69	\$545.36
NUCYNTA ER 150 MG TABLET	20	\$17,103.94	\$855.20
NUCYNTA ER 50 MG TABLET	7	\$1,603.11	\$229.02
OPANA ER 10 MG TABLET	13	\$3,525.06	\$271.16
OPANA ER 15 MG TABLET	2	\$503.92	\$251.96
OPANA ER 20 MG TABLET	13	\$6,649.33	\$511.49
OPANA ER 30 MG TABLET	13	\$8,751.40	\$673.18
OPANA ER 40 MG TABLET	22	\$21,033.99	\$956.09
OPANA ER 5 MG TABLET	12	\$1,834.88	\$152.91
OXYCODON-ACETAMINOPHEN 2.5-325	5	\$196.49	\$39.30
OXYCODON-ACETAMINOPHEN 7.5-325	222	\$10,233.19	\$46.10
OXYCODONE HCL 10 MG TABLET	795	\$22,039.74	\$27.72
OXYCODONE HCL 100 MG/5 ML SOLN	5	\$1,235.49	\$247.10
OXYCODONE HCL 15 MG TABLET	361	\$12,531.14	\$34.71
OXYCODONE HCL 20 MG TABLET	81	\$3,087.05	\$38.11
OXYCODONE HCL 30 MG TABLET	113	\$6,579.51	\$58.23
OXYCODONE HCL 5 MG CAPSULE	69	\$2,893.59	\$41.94
OXYCODONE HCL 5 MG TABLET	1,981	\$29,630.83	\$14.96
OXYCODONE HCL 5 MG/5 ML SOLN	102	\$3,925.12	\$38.48
OXYCODONE HCL ER 10 MG TABLET	106	\$13,317.88	\$125.64
OXYCODONE HCL ER 20 MG TABLET	87	\$21,380.93	\$245.76
OXYCODONE HCL ER 40 MG TABLET	105	\$40,228.73	\$383.13

SD Medicaid Opioid Utilization (AHFS 280808)

07/01/15 - 06/30/16

Label Name	Rx Num	Total Reimb Amt	Avg Cost per Script
OXYCODONE HCL ER 60 MG TABLET	1	\$695.84	\$695.84
OXYCODONE HCL ER 80 MG TABLET	26	\$16,464.66	\$633.26
OXYCODONE-ACETAMINOPHEN 10-325	1,093	\$92,906.60	\$85.00
OXYCODONE-ACETAMINOPHEN 5-325	3,943	\$53,088.31	\$13.46
OXYCODONE-ASPIRIN 4.8355-325	10	\$1,004.00	\$100.40
OXYCONTIN 10 MG TABLET	422	\$64,818.39	\$153.60
OXYCONTIN 15 MG TABLET	70	\$14,677.71	\$209.68
OXYCONTIN 20 MG TABLET	405	\$129,283.96	\$319.22
OXYCONTIN 30 MG TABLET	174	\$71,085.57	\$408.54
OXYCONTIN 40 MG TABLET	155	\$59,912.80	\$386.53
OXYCONTIN 60 MG TABLET	97	\$73,850.30	\$761.34
OXYCONTIN 80 MG TABLET	69	\$55,669.08	\$806.80
OXYMORPHONE HCL 10 MG TABLET	10	\$2,996.02	\$299.60
OXYMORPHONE HCL 5 MG TABLET	4	\$892.40	\$223.10
OXYMORPHONE HCL ER 10 MG TAB	7	\$1,658.05	\$236.86
OXYMORPHONE HCL ER 15 MG TAB	4	\$774.25	\$193.56
OXYMORPHONE HCL ER 20 MG TAB	2	\$450.20	\$225.10
OXYMORPHONE HCL ER 30 MG TAB	25	\$12,465.15	\$498.61
OXYMORPHONE HCL ER 40 MG TAB	7	\$5,383.38	\$769.05
TRAMADOL ER 100 MG TABLET	2	\$121.30	\$60.65
TRAMADOL ER 300 MG TABLET	3	\$425.58	\$141.86
TRAMADOL HCL 50 MG TABLET	11,192	\$91,744.06	\$8.20
TRAMADOL HCL ER 100 MG TABLET	68	\$6,254.65	\$91.98
TRAMADOL HCL ER 200 MG TABLET	47	\$4,674.49	\$99.46
TRAMADOL HCL ER 300 MG TABLET	38	\$4,747.39	\$124.93
TRAMADOL-ACETAMINOPHN 37.5-325	113	\$1,625.27	\$14.38
ULTRAM ER 300 MG TABLET	5	\$2,267.35	\$453.47
VICODIN 5-300 MG TABLET	24	\$1,326.93	\$55.29
VICODIN ES 7.5-300 MG TABLET	14	\$3,108.47	\$222.03
VICODIN HP 10-300 MG TABLET	2	\$481.51	\$240.76
ZAMICET 10-325 MG/15 ML SOLN	1	\$65.17	\$65.17
ZOXYDRO ER 10 MG CAPSULE	4	\$1,455.61	\$363.90
12,734 recipients	50,340	\$1,796,856.88	

1,573 recipients received ≥ 10 scripts per year

140 recipients received ≥ 30 scripts per year

Top 140 Recipients by Script Count							
7/1/2015 - 06/30/16							
Recipient	Script Count	Doctor Count	Sum of Reimb Amt	Sum of Days Supply	Avg Cost per Script	Avg Cost per Day	Avg Qty per Script
1	111	2	\$2,777.50	1094	\$25.02	\$2.54	19.64
2	78	4	\$2,238.47	1104	\$28.70	\$2.03	93.28
3	77	6	\$1,916.58	737	\$24.89	\$2.60	35.31
4	69	20	\$6,358.72	734	\$92.16	\$8.66	62.94
5	68	7	\$1,523.92	602	\$22.41	\$2.53	66.97
6	68	4	\$2,107.75	623	\$31.00	\$3.38	51.51
7	62	13	\$3,658.36	612	\$59.01	\$5.98	73.52
8	59	8	\$2,267.29	826	\$38.43	\$2.74	28.02
9	56	3	\$5,607.18	805	\$100.13	\$6.97	43.95
10	55	5	\$1,613.07	513	\$29.33	\$3.14	31.22
11	53	18	\$1,077.00	437	\$20.32	\$2.46	50.51
12	52	10	\$4,689.15	865	\$90.18	\$5.42	37.67
13	50	6	\$738.30	356	\$14.77	\$2.07	67.80
14	50	3	\$1,607.25	350	\$32.15	\$4.59	47.88
15	50	2	\$7,509.78	707	\$150.20	\$10.62	42.00
16	50	2	\$271.75	328	\$5.44	\$0.83	40.10
17	48	4	\$1,168.78	592	\$24.35	\$1.97	20.63
18	48	2	\$2,244.21	993	\$46.75	\$2.26	126.67
19	48	10	\$4,506.31	859	\$93.88	\$5.25	41.46
20	48	2	\$645.47	377	\$13.45	\$1.71	32.71
21	48	6	\$2,136.04	596	\$44.50	\$3.58	35.60
22	48	3	\$1,640.80	742	\$34.18	\$2.21	69.06
23	47	2	\$1,280.71	707	\$27.25	\$1.81	81.38
24	46	3	\$4,786.27	967	\$104.05	\$4.95	112.50
25	46	2	\$3,100.93	700	\$67.41	\$4.43	104.35
26	45	11	\$769.79	296	\$17.11	\$2.60	53.11
27	45	3	\$4,474.43	673	\$99.43	\$6.65	195.56
28	45	3	\$2,346.07	709	\$52.13	\$3.31	18.78
29	44	2	\$991.97	308	\$22.54	\$3.22	60.70
30	44	4	\$1,121.59	550	\$25.49	\$2.04	16.59
31	44	7	\$1,838.56	729	\$41.79	\$2.52	28.43
32	44	2	\$3,457.98	541	\$78.59	\$6.39	249.09

Top 140 Recipients by Script Count							
7/1/2015 - 06/30/16							
Recipient	Script Count	Doctor Count	Sum of Reimb Amt	Sum of Days Supply	Avg Cost per Script	Avg Cost per Day	Avg Qty per Script
33	44	4	\$4,128.46	1203	\$93.83	\$3.43	167.73
34	44	6	\$2,065.36	679	\$46.94	\$3.04	126.02
35	43	2	\$756.12	593	\$17.58	\$1.28	57.21
36	43	2	\$278.34	301	\$6.47	\$0.92	24.09
37	43	6	\$3,402.52	948	\$79.13	\$3.59	139.05
38	42	5	\$616.32	355	\$14.67	\$1.74	31.93
39	42	3	\$7,976.08	1151	\$189.91	\$6.93	75.40
40	41	3	\$1,989.54	788	\$48.53	\$2.52	57.85
41	41	5	\$2,888.06	1170	\$70.44	\$2.47	120.49
42	41	8	\$634.93	392	\$15.49	\$1.62	47.39
43	41	9	\$501.74	332	\$12.24	\$1.51	55.85
44	40	5	\$2,405.39	667	\$60.13	\$3.61	39.18
45	40	9	\$329.31	391	\$8.23	\$0.84	43.00
46	40	2	\$13,011.04	1151	\$325.28	\$11.30	129.68
47	40	7	\$1,755.83	682	\$43.90	\$2.57	32.48
48	39	2	\$3,254.66	1092	\$83.45	\$2.98	84.00
49	39	5	\$1,485.05	543	\$38.08	\$2.73	74.23
50	39	10	\$365.55	414	\$9.37	\$0.88	46.74
51	39	2	\$15,774.06	1093	\$404.46	\$14.43	100.00
52	39	4	\$1,961.93	651	\$50.31	\$3.01	38.97
53	39	5	\$917.82	528	\$23.53	\$1.74	34.41
54	39	2	\$10,628.53	1170	\$272.53	\$9.08	60.00
55	39	14	\$458.59	446	\$11.76	\$1.03	74.87
56	38	9	\$1,302.30	228	\$34.27	\$5.71	47.24
57	38	5	\$1,125.91	715	\$29.63	\$1.57	41.21
58	38	13	\$276.61	162	\$7.28	\$1.71	19.37
59	38	19	\$408.48	508	\$10.75	\$0.80	71.05
60	38	7	\$697.96	295	\$18.37	\$2.37	41.82
61	38	2	\$1,544.28	1085	\$40.64	\$1.42	92.37
62	37	10	\$3,220.41	594	\$87.04	\$5.42	120.92
63	37	13	\$4,431.06	641	\$119.76	\$6.91	77.14
64	37	2	\$2,158.04	510	\$58.33	\$4.23	97.19

Top 140 Recipients by Script Count							
7/1/2015 - 06/30/16							
Recipient	Script Count	Doctor Count	Sum of Reimb Amt	Sum of Days Supply	Avg Cost per Script	Avg Cost per Day	Avg Qty per Script
65	37	18	\$1,061.83	253	\$28.70	\$4.20	41.14
66	36	6	\$4,358.09	960	\$121.06	\$4.54	80.00
67	36	5	\$1,487.36	876	\$41.32	\$1.70	35.17
68	36	11	\$246.16	217	\$6.84	\$1.13	28.47
69	36	6	\$567.36	530	\$15.76	\$1.07	75.00
70	36	3	\$1,467.84	900	\$40.77	\$1.63	110.00
71	36	2	\$5,627.32	1005	\$156.31	\$5.60	115.83
72	36	12	\$2,181.60	350	\$60.60	\$6.23	46.47
73	36	3	\$2,364.12	790	\$65.67	\$2.99	67.50
74	36	2	\$13,458.62	990	\$373.85	\$13.59	150.00
75	35	5	\$2,063.01	878	\$58.94	\$2.35	27.43
76	35	6	\$194.21	272	\$5.55	\$0.71	24.03
77	35	12	\$1,036.64	813	\$29.62	\$1.28	64.00
78	35	2	\$12,677.51	723	\$362.21	\$17.53	73.71
79	35	2	\$6,753.99	1050	\$192.97	\$6.43	119.14
80	35	4	\$387.64	380	\$11.08	\$1.02	40.00
81	35	6	\$1,806.21	949	\$51.61	\$1.90	119.71
82	35	2	\$284.60	209	\$8.13	\$1.36	38.86
83	35	23	\$744.95	262	\$21.28	\$2.84	40.71
84	34	10	\$815.37	759	\$23.98	\$1.07	112.38
85	34	3	\$491.45	324	\$14.45	\$1.52	38.00
86	34	2	\$1,531.43	533	\$45.04	\$2.87	70.94
87	34	2	\$790.16	1020	\$23.24	\$0.77	152.65
88	34	6	\$255.18	387	\$7.51	\$0.66	65.32
89	34	2	\$839.28	974	\$24.68	\$0.86	126.47
90	34	7	\$363.08	521	\$10.68	\$0.70	51.03
91	34	5	\$9,572.19	682	\$281.54	\$14.04	83.41
92	34	5	\$545.33	338	\$16.04	\$1.61	37.59
93	34	24	\$280.05	129	\$8.24	\$2.17	22.26
94	34	2	\$3,865.17	476	\$113.68	\$8.12	69.97
95	34	2	\$3,704.30	630	\$108.95	\$5.88	57.35
96	33	15	\$3,417.22	424	\$103.55	\$8.06	42.67

Top 140 Recipients by Script Count							
7/1/2015 - 06/30/16							
Recipient	Script Count	Doctor Count	Sum of Reimb Amt	Sum of Days Supply	Avg Cost per Script	Avg Cost per Day	Avg Qty per Script
97	33	2	\$8,598.54	960	\$260.56	\$8.96	81.82
98	33	6	\$775.35	402	\$23.50	\$1.93	22.73
99	33	5	\$292.01	165	\$8.85	\$1.77	20.00
100	33	2	\$3,408.26	799	\$103.28	\$4.27	65.15
101	33	17	\$670.03	320	\$20.30	\$2.09	55.52
102	33	2	\$3,526.50	986	\$106.86	\$3.58	29.70
103	33	6	\$4,269.71	949	\$129.39	\$4.50	45.09
104	33	1	\$624.59	248	\$18.93	\$2.52	25.39
105	33	8	\$8,094.59	775	\$245.29	\$10.44	49.61
106	33	4	\$7,973.03	920	\$241.61	\$8.67	105.33
107	32	7	\$1,204.58	753	\$37.64	\$1.60	53.44
108	32	3	\$1,601.24	430	\$50.04	\$3.72	107.25
109	32	5	\$233.20	389	\$7.29	\$0.60	51.34
110	32	10	\$1,729.78	533	\$54.06	\$3.25	64.72
111	32	2	\$3,631.42	896	\$113.48	\$4.05	85.25
112	32	11	\$453.71	501	\$14.18	\$0.91	96.00
113	32	5	\$951.33	573	\$29.73	\$1.66	51.41
114	32	2	\$8,401.36	905	\$262.54	\$9.28	56.69
115	32	10	\$744.64	361	\$23.27	\$2.06	83.56
116	32	4	\$1,354.30	829	\$42.32	\$1.63	191.97
117	31	2	\$2,060.45	900	\$66.47	\$2.29	38.06
118	31	8	\$4,556.55	654	\$146.99	\$6.97	60.52
119	31	8	\$1,039.88	634	\$33.54	\$1.64	73.87
120	31	2	\$13,284.02	906	\$428.52	\$14.66	86.00
121	31	13	\$1,162.51	447	\$37.50	\$2.60	107.68
122	31	8	\$193.88	360	\$6.25	\$0.54	50.00
123	31	14	\$555.51	295	\$17.92	\$1.88	50.06
124	31	6	\$2,993.71	850	\$96.57	\$3.52	116.29
125	31	8	\$1,672.48	661	\$53.95	\$2.53	59.77
126	31	16	\$339.39	422	\$10.95	\$0.80	68.97
127	30	13	\$8,464.44	626	\$282.15	\$13.52	101.90
128	30	8	\$683.53	404	\$22.78	\$1.69	39.63

Top 140 Recipients by Script Count							
7/1/2015 - 06/30/16							
Recipient	Script Count	Doctor Count	Sum of Reimb Amt	Sum of Days Supply	Avg Cost per Script	Avg Cost per Day	Avg Qty per Script
129	30	10	\$519.53	568	\$17.32	\$0.91	84.70
130	30	12	\$5,686.72	524	\$189.56	\$10.85	72.73
131	30	9	\$1,684.45	508	\$56.15	\$3.32	155.73
132	30	3	\$334.43	526	\$11.15	\$0.64	42.00
133	30	2	\$5,983.06	840	\$199.44	\$7.12	103.00
134	30	5	\$2,241.55	741	\$74.72	\$3.03	68.07
135	30	3	\$1,601.72	428	\$53.39	\$3.74	56.00
136	30	15	\$572.99	391	\$19.10	\$1.47	73.43
137	30	2	\$2,423.16	302	\$80.77	\$8.02	92.00
138	30	4	\$710.07	379	\$23.67	\$1.87	66.87
139	30	2	\$9,710.05	900	\$323.67	\$10.79	92.00
140	30	13	\$534.64	330	\$17.82	\$1.62	39.47

Top Prescribers/Counties

Top 20 Prescribers of Opioids	
Rx Count	Specialty
1021	Family Practice
940	Family Practice
746	Physical Medicine/Rehab
666	Pain Management
386	Family Practice
336	Internal Medicine
323	Internal Medicine
236	Physiatrist
206	Family Practice
198	Family Practice
192	Family Practice
191	Family Practice
184	Family Practice
166	Family Practice
166	Family Practice
162	Family Practice
160	Pain Management
160	Emergency Medicine
159	Pain Management
158	Family Practice

Top 20 Counties by Recipient Count		
County	Recip Count	Rx Count
Minnehaha	2050	8114
Pennington	1645	5553
Todd	491	2243
Shannon	435	1283
Brown	376	1619
Yankton	305	1390
Davison	249	853
Hughes	245	930
Codington	243	913
Meade	233	778
Lawrence	223	762
Beadle	211	873
Dewey	184	553
Brookings	180	805
Lincoln	178	493
Butte	168	591
Charles Mix	161	683
Corson	152	684
Roberts	140	627
Clay	129	753

SD Medicaid Gabapentin Utilization			
04/01/15 - 03/31/16			
Label Name	Rx Num	Total Reimb Amt	Avg Cost per Script
GABAPENTIN 100 MG CAPSULE	1241	\$14,696.23	\$11.84
GABAPENTIN 250 MG/5 ML	173	\$5,546.92	\$32.06
GABAPENTIN 300 MG CAPSULE	4686	\$71,940.27	\$15.35
GABAPENTIN 400 MG CAPSULE	494	\$9,470.57	\$19.17
GABAPENTIN 600 MG TABLET	1643	\$43,946.28	\$26.75
GABAPENTIN 800 MG TABLET	469	\$11,814.65	\$25.19
GRALISE ER 300 MG TABLET	3	\$511.62	\$170.54
GRALISE ER 600 MG TABLET	10	\$6,753.36	\$675.34
NEURONTIN 300 MG CAPSULE	4	\$884.00	\$221.00
1702 recipients	8724	\$165,563.90	
73% of recipients taking gabapentin are also taking narcotics			

Age	Recip Count
1-10	15
11-20	67
21-30	218
31-40	429
41-50	382
51+	591

SD Medicaid Pregabalin Utilization			
04/01/15 - 03/31/16			
Label Name	Rx Num	Total Reimb Amt	Avg Cost per Script
LYRICA 25 MG CAPSULE	40	\$13,620.04	\$340.50
LYRICA 50 MG CAPSULE	418	\$158,386.00	\$378.91
LYRICA 75 MG CAPSULE	677	\$243,080.53	\$359.06
LYRICA 100 MG CAPSULE	569	\$234,205.02	\$411.61
LYRICA 150 MG CAPSULE	818	\$313,107.61	\$382.77
LYRICA 200 MG CAPSULE	256	\$100,847.25	\$393.93
LYRICA 300 MG CAPSULE	180	\$60,185.60	\$334.36
LYRICA 225 MG CAPSULE	34	\$10,646.17	\$313.12
549 recipients	2992	\$1,134,078.22	
82% of recipients taking pregabalin are also taking narcotics			

Age	Recip Count
1-10	1
11-20	12
21-30	45
31-40	134
41-50	157
51+	200

From 05/01/16 to 07/31/16, 25 patients took both pregabalin and gabapentin; 14 were prescribed by different doctors



**XENAZINE
PRIOR AUTHORIZATION**
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

**Fax Completed Form to:
866-254-0761**
**For questions regarding this
Prior authorization, call
866-705-5391**

SD Medicaid requires that patients receiving a new prescription for Xenazine must meet the following criteria:

- Patient must have a confirmed diagnosis of chorea associated with Huntington's disease.
- Patient must have a specialist involved in therapy.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	SPECIALIST INVOLVED IN THERAPY:
CITY:	PHONE: ()	FAX: ()

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested drug and dosage:	Diagnosis for this Request:	Does the patient have impaired hepatic function? <input type="checkbox"/> YES <input type="checkbox"/> NO Will Xenazine be used in combination with a monoamine oxidase inhibitor (MAOI) or reserpine? <input type="checkbox"/> YES <input type="checkbox"/> NO
PHYSICIAN SIGNATURE:	DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ()	FAX: ()
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	



ONFI
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Onfi must meet the following criteria:

- Patient must have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS).
- Patient must be 2 years of age or older.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH
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Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ()	FAX: ()

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: <input type="checkbox"/> Onfi	Diagnosis for this request:
Dosing Instructions:	
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ():	FAX: ()
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

SD Medicaid Onfi Utilization			
07/01/15 - 06/30/16			
Label Name	Rx Num	Total Reimb Amt	Avg Cost per Script
ONFI 10 MG TABLET	6	\$3,260.97	\$543.50
ONFI 2.5 MG/ML SUSPENSION	283	\$196,043.30	\$692.73
ONFI 10 MG TABLET	306	\$336,375.12	\$1,099.27
ONFI 20 MG TABLET	90	\$84,354.47	\$937.27
73 recipients	685	\$620,033.86	

Age	Recip Count
0-5	14
6-10	21
11-15	21
16-20	12
20+	5

Diagnoses	Recip Count
OTH GEN EPILEPSY NOT INTRACTABLE W/O STAT EPI	4
EPILEPSY UNSP NOT INTRACTABLE WITHOUT STATUS EPI	22
CONVERSION DISORDER WITH SEIZURES OR CONVULSIONS	1
GEN IDIOPATHIC EPILEPSY INTRACTABLE W/O STAT EPI	6
LOC-REL SYM EPI W CM PR SEIZ,X NTRCT,W/O STA EPI	5
SIMPLE FEBRILE CONVULSIONS	1
OTHER CONVULSIONS	2
UNSPECIFIED CONVULSIONS	5
EPILEPSY UNSP NOT INTRACTABLE WITH STATUS EPI	2
LENNOX-GASTAUT SYNDROME NOT INTRACT W/O STAT EPI	10
OTHER EPILEPSY INTRACTABLE WITHOUT STATUS EPI	3
UNS EPILEPSY WO INTRACT EPILEPSY	1
JUVENILE MYOCLONIC EPILEPSY INTRACT W/O STAT EPI	1
EPILEPSY UNSP INTRACTABLE WITHOUT STATUS EPI	1
NONE	9

SD Medicaid Benzodiazepine Utilization

07/01/15 - 06/30/16

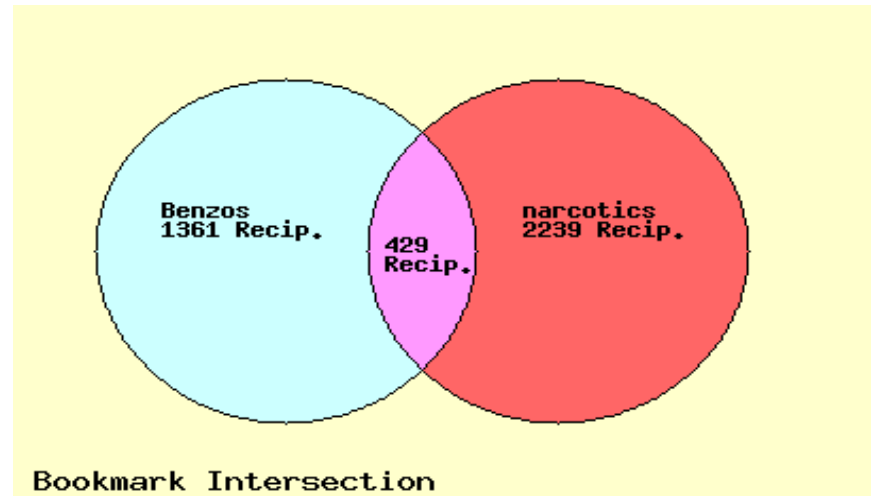
Label Name	Rx Num	Total Reimb Amt	Avg Cost per Script
ALPRAZOLAM 0.25 MG TABLET	742	\$4,200.34	\$5.66
ALPRAZOLAM 0.5 MG TABLET	1370	\$7,617.97	\$5.56
ALPRAZOLAM 1 MG TABLET	1357	\$10,450.76	\$7.70
ALPRAZOLAM 2 MG TABLET	284	\$2,974.18	\$10.47
ALPRAZOLAM ER 0.5 MG TABLET	10	\$196.00	\$19.60
ALPRAZOLAM ER 1 MG TABLET	29	\$558.30	\$19.25
ALPRAZOLAM ER 2 MG TABLET	17	\$345.29	\$20.31
ALPRAZOLAM XR 2 MG TABLET	2	\$61.30	\$30.65
CHLORDIAZEPOXIDE 10 MG CAPSULE	1	\$8.01	\$8.01
CHLORDIAZEPOXIDE 25 MG CAPSULE	21	\$189.74	\$9.04
CHLORDIAZEPOXIDE 5 MG CAPSULE	2	\$12.99	\$6.50
CLONAZEPAM 0.125 MG DIS TAB	38	\$1,378.35	\$36.27
CLONAZEPAM 0.25 MG ODT	113	\$5,574.77	\$49.33
CLONAZEPAM 0.5 MG DIS TABLET	78	\$2,262.94	\$29.01
CLONAZEPAM 0.5 MG TABLET	3190	\$18,617.18	\$5.84
CLONAZEPAM 1 MG DIS TABLET	121	\$3,463.87	\$28.63
CLONAZEPAM 1 MG TABLET	3167	\$22,283.01	\$7.04
CLONAZEPAM 2 MG ODT	4	\$72.53	\$18.13
CLONAZEPAM 2 MG TABLET	297	\$2,074.04	\$6.98
CLORAZEPATE 3.75 MG TABLET	240	\$8,326.78	\$34.69
CLORAZEPATE 7.5 MG TABLET	94	\$1,281.14	\$13.63
DIASTAT 2.5 MG PEDI SYSTEM	6	\$1,496.28	\$249.38
DIASTAT ACUDIAL 12.5-15-20 MG	4	\$742.62	\$185.66
DIASTAT ACUDIAL 5-7.5-10 MG KT	25	\$7,616.78	\$304.67
DIAZEPAM 10 MG RECTAL GEL SYST	149	\$40,105.48	\$269.16
DIAZEPAM 10 MG TABLET	513	\$2,640.54	\$5.15
DIAZEPAM 10 MG/2 ML CARPUJECT	3	\$36.30	\$12.10
DIAZEPAM 2 MG TABLET	190	\$1,016.93	\$5.35
DIAZEPAM 2.5 MG RECTAL GEL SYS	10	\$2,395.80	\$239.58
DIAZEPAM 20 MG RECTAL GEL SYST	34	\$9,281.88	\$273.00
DIAZEPAM 5 MG TABLET	1382	\$6,943.69	\$5.02
DIAZEPAM 5 MG/5 ML SOLUTION	97	\$1,537.00	\$15.85
DIAZEPAM 5 MG/ML ORAL CONC	51	\$1,473.03	\$28.88
ESTAZOLAM 1 MG TABLET	3	\$41.40	\$13.80
ESTAZOLAM 2 MG TABLET	20	\$287.00	\$14.35
FLURAZEPAM 15 MG CAPSULE	16	\$174.04	\$10.88
FLURAZEPAM 30 MG CAPSULE	11	\$74.38	\$6.76
KLONOPIN 1 MG TABLET	2	\$639.52	\$319.76
LORAZEPAM 0.5 MG TABLET	2693	\$17,270.07	\$6.41
LORAZEPAM 1 MG TABLET	2446	\$16,670.14	\$6.82
LORAZEPAM 2 MG TABLET	310	\$2,651.31	\$8.55
LORAZEPAM 2 MG/ML ORAL CONCENT	35	\$525.65	\$15.02
LORAZEPAM 2 MG/ML VIAL	6	\$61.62	\$10.27
LORAZEPAM 20 MG/10 ML VIAL	1	\$11.48	\$11.48

SD Medicaid Benzodiazepine Utilization			
07/01/15 - 06/30/16			
Label Name	Rx Num	Total Reimb Amt	Avg Cost per Script
LORAZEPAM INTENSOL 2 MG/ML	60	\$960.11	\$16.00
MIDAZOLAM HCL 10 MG/2 ML VIAL	2	\$55.90	\$27.95
MIDAZOLAM HCL 2 MG/ML SYRUP	4	\$318.65	\$79.66
MIDAZOLAM HCL 5 MG/ML VIAL	4	\$62.98	\$15.75
ONFI 10 MG TABLET	312	\$339,636.09	\$1,088.58
ONFI 2.5 MG/ML SUSPENSION	283	\$196,043.30	\$692.73
ONFI 20 MG TABLET	90	\$84,354.47	\$937.27
TEMAZEPAM 15 MG CAPSULE	209	\$1,504.12	\$7.20
TEMAZEPAM 22.5 MG CAPSULE	15	\$4,998.80	\$333.25
TEMAZEPAM 30 MG CAPSULE	284	\$2,132.78	\$7.51
TEMAZEPAM 7.5 MG CAPSULE	33	\$4,352.15	\$131.88
TRIAZOLAM 0.125 MG TABLET	1	\$4.70	\$4.70
TRIAZOLAM 0.25 MG TABLET	92	\$2,354.19	\$25.59
3,907 recipients	20573	\$842,420.67	

718 recipients received ≥ 10 scripts per year

Top 20 Recipients of Benzodiazepines by Script Count						
07/01/15 - 06/30/16						
Script Count	Doctor Count	Sum of Reimb Amt	Sum of Days Supply	Avg Cost per Script	Avg Cost per Day	Avg Qty per Script
52	4	\$240.81	396	\$4.63	\$0.61	21
49	3	\$207.07	341	\$4.23	\$0.61	21
45	5	\$218.42	365	\$4.85	\$0.60	32
44	5	\$284.67	371	\$6.47	\$0.77	25
41	5	\$314.86	1065	\$7.68	\$0.30	70
38	4	\$364.53	504	\$9.59	\$0.72	30
37	7	\$161.92	361	\$4.38	\$0.45	29
37	4	\$169.57	247	\$4.58	\$0.69	20
37	1	\$143.19	273	\$3.87	\$0.52	7
36	4	\$753.30	702	\$20.93	\$1.07	39
35	7	\$236.31	760	\$6.75	\$0.31	42
35	2	\$195.69	350	\$5.59	\$0.56	29
35	1	\$195.21	316	\$5.58	\$0.62	24
33	2	\$232.43	990	\$7.04	\$0.23	50
33	4	\$238.22	451	\$7.22	\$0.53	49
33	3	\$10,717.52	265	\$324.77	\$40.44	48
31	9	\$366.15	789	\$11.81	\$0.46	51
31	5	\$198.46	801	\$6.40	\$0.25	72
30	2	\$323.74	900	\$10.79	\$0.36	68
30	5	\$206.88	900	\$6.90	\$0.23	49

Patients receiving a prescription for a benzodiazepine and a narcotic in July 2016



PRODUCT DETAILS OF ZINBRYTA (DACLIZUMAB)

INDICATIONS AND USE:

Zinbryta is an interleukin-2 receptor blocking antibody indicated for the treatment of adult patients with relapsing forms of multiple sclerosis.

DOSAGE AND ADMINISTRATION:

Recommended dosage is 150 mg once monthly.

DOSAGE FORM AND STRENGTHS:

Injection: 150 mg/mL solution in a single-dose prefilled syringe.

CONTRAINDICATIONS:

- Pre-existing hepatic disease or hepatic impairment, including ALT or AST.
- History of autoimmune hepatitis or other autoimmune condition involving the liver.

WARNINGS AND PRECAUTIONS:

- Risk of anaphylaxis and angioedema.
- Increased risk of infections.
- Advise patients to immediately report symptoms of depression and/or suicidal ideation to their health care provider.

ADVERSE REACTIONS:

The most common adverse reactions were nasopharyngitis, upper respiratory tract infection, rash, influenza, dermatitis, oropharyngeal pain, bronchitis, eczema, and lymphadenopathy.

DRUG INTERACTIONS:

Hepatotoxic drugs: Evaluate potential for increased risk of hepatotoxicity with concomitant use.

References:

1. Zinbryta [package insert]. Cambridge, MA: Biogen, Inc.; May 2016.

PRODUCT DETAILS OF BYVALSON (NEBIVOLOL AND VALSARTAN)

INDICATIONS AND USE:

Byvalson is a beta adrenergic blocker and an angiotensin II receptor blocker (ARB) indicated for the treatment of hypertension to lower blood pressure.

DOSAGE AND ADMINISTRATION:

- As initial therapy and in patients not adequately controlled on valsartan 80 mg or nebivolol up to and including 10 mg, the recommended dose is 5 mg/80 mg taken orally once daily.
- Maximum antihypertensive effects are attained within 2 to 4 weeks.

DOSAGE FORM AND STRENGTHS:

Tablets: 5 mg/80 mg.

CONTRAINDICATIONS:

- Severe bradycardia
- Heart block greater than first degree
- Patients with cardiogenic shock
- Decompensated cardiac failure
- Sick sinus syndrome (unless a permanent pacemaker is in place)
- Patients with severe hepatic impairment (Child-Pugh >B)
- Do not co-administer aliskiren with Byvalson in patients with diabetes

WARNINGS AND PRECAUTIONS:

- Acute exacerbation of coronary artery disease upon cessation of therapy. Do not abruptly discontinue.
- Monitor glucose as beta-blockers may mask symptoms of hypoglycemia.
- Monitor renal function and potassium in susceptible patients.

ADVERSE REACTIONS:

No adverse reactions were observed more frequently on Byvalson than on placebo.

DRUG INTERACTIONS:

- CYP2D6 enzyme inhibitors increase nebivolol levels.

- Reserpine or clonidine may produce excessive reduction of sympathetic activity.
- Digitalis glycosides increase the risk of bradycardia.
- Verapamil- or diltiazem-type calcium channel blockers may cause excessive reductions in heart rate, blood pressure, and cardiac contractility.
- Potassium sparing diuretics, potassium supplements, or salt substitutes may lead to increases in serum potassium.
- NSAID use may lead to increased risk of renal impairment and loss of antihypertensive effect.
- Dual inhibition of the renin-angiotensin system causing increased risk of renal impairment, hypotension, and hyperkalemia.
- May cause increases in serum lithium concentrations and lithium toxicity.

References:

1. Byvalson [package insert]. Irvine, CA: Allergan USA, Inc.; June 2016.