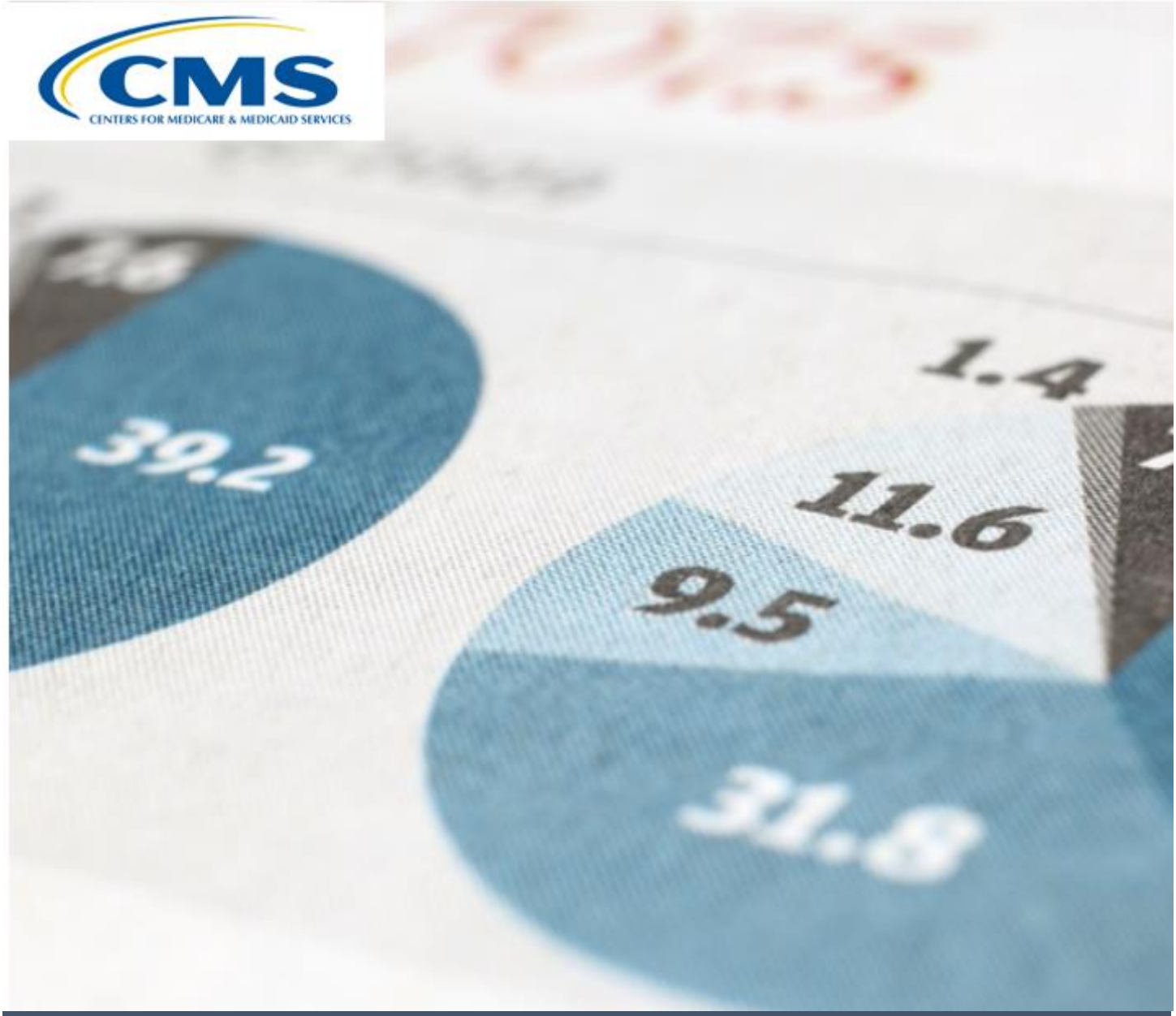


Florida
Medicaid Fee-For-Service (FFS)
2019 Drug Utilization Review (DUR)

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Florida DUR 2019 FFS Individual State Report

Section I – Number of Beneficiaries

Question	Response
1. On average, how many of your state's Medicaid beneficiaries are enrolled in your state's Medicaid Fee-For-Service (FFS) program that have a pharmacy benefit?	**837,952**
2. On average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)?	**2,992,055**

Section II - Prospective DUR (ProDUR)

Question	Response
1. Indicate the type of your pharmacy point of service (POS) vendor.	**Contractor**
a. Vendor Name	**Magellan Medicaid Administration, Inc.**
b. If not state-operated, is the POS vendor also the MMIS fiscal agent or a separate PBM?	**No**
2. Identify ProDUR criteria source.	**First Databank**
If "Other," please specify	N/A
3. Are new ProDUR criteria approved by the DUR Board?	**Yes**
If "No," please explain	N/A
4. When the pharmacist receives a level-one ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?	**Yes**
If "varies," please explain	N/A
5. Do you receive and review follow-up reports providing individual pharmacy provider DUR alert override activity in summary and/or in detail?	**No**
a. If "Yes," how often do you receive reports?	**N/A**
If "Other," please explain	N/A

Question	Response
b. If you receive reports, do you follow up with those providers who routinely override with interventions?	**N/A**
If "Yes," by what method do you follow up?	N/A
If "Other," please explain.	N/A
If "No," please explain	N/A
If "No," please explain	ProDUR alerts are an indication of the edits previously established by the DUR Board. The DUR board makes upfront decisions on whether edits should be overridden at the pharmacy level (based on clinical judgement). The programming is then implemented to reflect soft or hard edits. Therefore, a pharmacist is only able to override those alerts that the board has pre-determined should be left to their discretion (as soft edits). ProDUR monitoring reports are not generated outside of the standard fiscal monitoring of Medicaid Program integrity. The Bureau of Medicaid Program Integrity reviews the pharmacy provider activity, not Pharmacy policy.
6. Early Refill	
a. At what percent threshold do you set your system to edit?	
i) Non-controlled drugs:	**80%**
ii) Schedule II controlled drugs:	**90%**
iii) Schedule III through V controlled drugs:	**90%**
b. For non-controlled drugs: When an early refill message occurs, does the state require prior authorization?	**Yes**
If "Yes" or "Dependent on medication or situation," who obtains authorization?	Pharmacist or Prescriber
If "No," can the pharmacist override at the point of service?	N/A
c. For controlled drugs: When an early refill message occurs, does the state require prior authorization?	**Yes**
If "Yes," who obtains authorization?	Prescriber
If "No," can the pharmacist override at the point of service?	N/A
7. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's	

Question	Response
review, does your state's policy allow the pharmacist to override for situations such as:	
a. Lost/stolen Rx	**No**
b. Vacation	**No**
c. "Other," please explain.	**N/A**
8. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?	**Yes**
If "Yes," please explain your edit.	Certain classes have accumulation edits (proton pump inhibitors, skeletal muscle relaxants, and controlled substances). The edit counts refills over a particular time frame to prohibit a total accumulation amount.
If "No," do you plan to implement this edit?	N/A
9. Does the state Medicaid agency or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?	**Yes**
10. Does the state Medicaid agency have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled, chronic medication refills at the same time, the state would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?	**No**
11. For drugs not on your formulary, does your agency have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?	**Yes**
If "Yes," what is the preauthorization process?	Non-preferred medications with set criteria and prior authorization forms are posted on the Agency for Health Care Administration Pharmacy Policy site (https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/paforms.shtml). Medications that do not have set criteria can be submitted on the miscellaneous prior

Question	Response
	authorization form. The forms list the requirements and documentation necessary for review. The clinical reviewers have 24 hours to review the prior authorization request and provide a response.
If "No," please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.	N/A
a. Does your program provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation?	**Yes**
If "Yes," what is the process?	In the event of a natural disaster, the Bureau Chief will work with Magellan Medicaid Administration to selectively open payment to counties under threat. In the event of a fire or catastrophic loss, one early refill per year may be granted for non-controlled substances. The beneficiary's provider must submit an early refill request with a copy of the official police report. Medications that qualify for approval include those that prevent hospitalization (i.e., diabetic and blood pressure mediation), have a significant societal impact (i.e., seizure and HIV/AIDS medication), or used to treat major mental health disorders (i.e., schizophrenia, bipolar disorder, major depression).
If "No," please explain.	N/A
12. Please list the requested data in each category in *Table 1 - Top Drug Claims Data Reviewed by the DUR Board* that follows	

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

Top 10 Prior Authorization (PA) Requests by Drug Name	Top 10 Prior Authorization (PA) Requests by Drug Class	Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications and Age Edits)	Top 10 Drug Names by Amount Paid	% of Total Spent for Drugs by Amount Paid (From data in Column 4, Determine the % of total drug spend)	Top 10 Drug Names by Claim Count	Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)
EPIDIOLEX (CANNABIDIOL)	MISCELLANEOUS	Dur reject error	ELOCTATE (ANTIHEMOPHILI	6.48%	(MONTELUKAST SODIUM)	1.81%

Top 10 Prior Authorization (PA) Requests by Drug Name	Top 10 Prior Authorization (PA) Requests by Drug Class	Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications and Age Edits)	Top 10 Drug Names by Amount Paid	% of Total Spent for Drugs by Amount Paid (From data in Column 4, Determine the % of total drug spend)	Top 10 Drug Names by Claim Count	Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)
			C FACTOR, FC FUSION PROTEIN, RECOMBINANT)			
(METHYLPHENIDATE ER)	ANTICONVULSANTS	Plan limitations exceeded	HEMLIBRA (EMICIZUMAB)	2.89%	(CLONIDINE HCL)	1.69%
XIFAXAN (RIFAXIMIN)	OTHER ANTIBIOTICS	Prior authorization required	ADVATE (ANTIHEMOPHILIC FACTOR, AHF, FACTOR VIII)	2.71%	(RISPERIDONE)	1.55%
XOLAIR (OMALIZUMAB)	BRONCHIAL DILATORS	Product/Service Not Covered - plan/benefit exclusion	SPINRAZA (NUSINERSEN)	2.10%	PROAIR HFA (ALBUTEROL SULFATE)	1.50%
QVAR REDIHALER (BECLOMETHASONE DIPROPIONATE)	DIABETIC THERAPY	Product/Service Not Covered For Patient Age	BIKTARVY (BICTEGRAVIR; EMTRICITABINE; TENOFOVIR ALAFENAMIDE)	2.01%	(LEVETIRACETAM)	1.47%
CARAFATE (SUCRALFATE)	CNS STIMULANTS		GENVOYA (ELVITEGRAVIR; COBICISTAT; EMTRICITABINE; TENOFOVIR ALAFENAMIDE)	1.77%	(FLUTICASONE PROPIONATE)	1.41%
(LEVALBUTEROL HCL)	ANTINEOPLASTICS		VIMPAT (LACOSAMIDE)	1.62%	(GABAPENTIN)	1.37%
MAVYRET (GLECAPREVIR/PIBRENTASVIR)	GLUCOCORTICOIDS		KOGENATE FS (ANTIHEMOPHILIC FACTOR, AHF, FACTOR VIII)	1.43%	(LEVOTHYROXINE SODIUM)	1.33%
(EPINEPHRINE)	ANTI-ULCER PREPS/GASTROINTESTINAL PREPS		PULMOZYME (DORNASE ALPHA)	1.41%	(TRAZODONE HCL)	1.25%
JADENU (DEFERASIROX)	ANTIVIRALS		IBRANCE (PALBOCICLIB)	1.36%	(CETIRIZINE HCL)	1.24%

Question	Response
13. Section 1927(g)(A) of the Social Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in your	**Medicaid agency, State Board of Pharmacy**

Question	Response
state has responsibility for monitoring compliance with the oral counseling requirement? Check all that apply:	
If "Other," please explain:	N/A
14. Summary 1 – Pharmacy Oral Counseling Compliance Summary 1 Pharmacy Oral Counseling Compliance reports the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid Agency, the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid Agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the Omnibus Budget Reduction Act (OBRA) of 1990 prospective DUR requirement. This report details state efforts to monitor pharmacy compliance with the oral counseling requirement and should describe in detail, utilizing the text box below, the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.	**Florida Medicaid Pharmacy Program** **Drug Utilization Review Annual Report: FFY19** **Pharmacy Oral Counseling Compliance Report** **Currently all Florida Prospective Drug Utilization Review (DUR) requirements are electronic with the exception of patient counseling. All pharmacists are required to submit each claim through the point-of-sale system in order to receive payment from Florida Medicaid. With each electronic claim submission, the claim is reviewed against the past 90 days of claims for age specific appropriate dosing, early refill, therapeutic or ingredient duplication and drug-to-drug interactions.** **The Florida Medicaid Program Integrity Bureau monitors pharmacy compliance with the OBRA 1990 oral counseling requirement. Pharmacy surveys are conducted in which a questionnaire is used to access oral counseling compliance. During the fiscal year period of October 1, 2018 to September 30, 2019, 1 survey was conducted including the questionnaire. The pharmacy demonstrated they were compliant with OBRA requirements to offer counseling.** **64B16-27.820 Patient Counseling.** **(1) Upon receipt of a new or refill prescription, the pharmacist shall ensure that a verbal and printed offer to counsel is made to the patient or the patient's agent when present. If the delivery of the drugs to the patient or the patient's agent is not made at the pharmacy the offer shall be in writing and shall provide for toll-free telephone access to the pharmacist. If the patient does not refuse such counseling, the pharmacist, or the pharmacy intern, acting under the direct and immediate personal supervision of a licensed pharmacist, shall review the patient's record and personally discuss matters which will**

Question	Response
	enhance or optimize drug therapy with each patient or agent of such patient. Such discussion shall be in person, whenever practicable, by toll-free telephonic communication, or by an interactive audio and digital image format, and shall include appropriate elements of patient counseling. Such elements may include, in the professional judgment of the pharmacist, the following: **(a) The name and description of the drug;** **(b) The dosage form, dose, route of administration, and duration of drug therapy;** **(c) Intended use of the drug and expected action (if indicated by the prescribing health care practitioner);** **(d) Special directions and precautions for preparation, administration, and use by the patient;** **(e) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;** **(f) Techniques for self-monitoring drug therapy;** **(g) Proper storage;** **(h) Prescription refill information;** **(i) Action to be taken in the event of a missed dose;** **(j) The potential for physical dependence, addiction, misuse, or abuse; and** **(k) Pharmacist comments relevant to the individual's drug therapy, including any other information peculiar to the specific patient or drug.** **(2) Patient counseling as described herein, shall not be required for inpatients of a hospital or institution where other licensed health care practitioners are authorized to administer the drug(s).** **(3) A pharmacist shall not be required to counsel a patient or a patient's agent when the patient or patient's agent refuses such consultation.** **Rulemaking Authority 465.022, 465.0155 FS. Law Implemented 465.0155 FS. History New 8-18-93, Formerly 21S-27.820, 61F10-27.820,**

Question	Response
	59X-27.820, Amended 7-11-18.

Section III - RETROSPECTIVE DUR (RetroDUR)

Question	Response
1. Indicate the type of vendor that performed your RetroDUR activities during the time period covered by this report.	**Company**
a. Identify, by name, your RetroDUR vendor.	**Magellan Medicaid Administration**
b. Is the RetroDUR vendor also the MMIS fiscal agent?	**No**
c. Is the RetroDUR vendor also the developer/supplier of your retrospective DUR criteria?	**No**
If "No," please explain	The developer of the retrospective DUR criteria is provided by the State DUR Board in collaboration with the Agency.
2. Who reviews and approves the RetroDUR criteria?	**State DUR Board**
"Other," please explain	N/A
3. Summary 2 – Retrospective DUR Educational Outreach Summary 2 Retrospective DUR Educational Outreach is a year-end summary report on RetroDUR screening and educational interventions. The year-end summary should be limited to the most prominent 10 problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed.	**Top 10 Retrospective DUR Education Outreach** **1. Exception Period Covered by Run: 01/01/2017-05/31/2017** **Problem Type Description: Therapeutic Appropriateness/Safety/Overutilization** **Criteria Description: Recipients using more than two unique antipsychotic therapies** **Number of Exceptions Per Problem Type: 2,041 recipients** **Results of RetroDUR Screening and Interventions: The DUR Board voted to implement an edit to limit a recipient to two antipsychotics with unique chemical entity per 30 days. The third antipsychotic would require a clinical prior authorization. The DUR Board reviewed and approved the criteria for approval. The edit deployed on 09/19/19.**

	2. Exception Period Covered by Run: 10/1/2017-12/31/2017 **Problem Type Description: Safety** **Criteria Description: Review utilization of opiate containing cough and cold preparations and percentage of utilization in children under 18 years of age** **Number of Exceptions Per Problem Type: 9 recipients** **Results of RetroDUR Screening and Interventions: Given the risks of opiate containing cough and cold preparations in children, the DUR Board voted to change age minimum to 18 following the FDA safety alert recommendations. The edit deployed on 05/14/18. The DUR Board reviewed the post impact data run from 05/15/18-08/15/18. The DUR Board determined no further intervention was required as there was a 100% decline in claims for children less than 18 years of age.** **3. Exception Period Covered by Run: 01/01/2018-03/31/2018** **Problem Type Description: Therapeutic Appropriateness/Safety/Overutilization** **Criteria Description: Review utilization and appropriate age limitations for oral codeine in children under 12 years of age** **Number of Exceptions Per Problem Type: 50 claims** **Results of RetroDUR Screening and Interventions: The DUR Board voted to update the age minimum of oral codeine products from six to twelve years of age following the FDA safety alert and the DUR Board reviewed the post impact data.** **4. Exception Period Covered by Run: 01/01/2018-06/30/2018** **Problem Type Description: Therapeutic Appropriateness/Safety/Overutilization** **Criteria Description: Overutilization of selected topical products and review of off-label usage** **Number of Exceptions Per Problem Type: 301 claims** **Results of RetroDUR Screening and Interventions: The DUR Board voted to implement an automated prior authorization on all formulations of Calcipotriene for age,**

	diagnosis, and duration of therapy and the DUR Board voted to create an automated prior authorization for Doxepin 5% cream to include diagnosis. **5. Exception Period Covered by Run: 10/01/2018-12/31/2018** **Problem Type Description: Safety** **Criteria Description: Review concomitant utilization of opiates and antipsychotics** **Number of Exceptions Per Problem Type: 351 recipients; 1,722 claims** **Results of RetroDUR Screening and Interventions: The DUR Board reviewed the impact data. In response to the Support Act, a soft edit was deployed for recipients on concomitant therapy. The dispensing pharmacist has the capability to override the claim at the point of sale with approved DUR intervention codes. Seizure, Cancer/Palliative Care, Sickle Cell and Long Term Care (LTC) recipients are excluded from the soft edit. The edit deployed on 09/27/19.** **6. Exception Period Covered by Run: 10/01/2018-12/31/2018** **Problem Type Description: Safety** **Criteria Description: Review utilization of opiates and Narcan (Naloxone)** **Number of Exceptions Per Problem Type: 73 recipients; 198 claims** **Results of RetroDUR Screening and Interventions: The DUR Board reviewed the impact and will continue to monitor opiate claims for appropriate use.** **7. Exception Period Covered by Run: 10/06/2018-01/06/2019** **Problem Type Description: Safety** **Criteria Description: To review the post impact of the Zolpidem step therapy edit** **Number of Exceptions Per Problem Type: 96 recipients** **Results of RetroDUR Screening and Interventions: The DUR Board reviewed the post impact data and there was a significant decline (94%) in patients starting therapy at the higher dose.** **8. Exception Period Covered by Run: 01/01/2019-03/31/2019**

	Problem Type Description: Safety **Criteria Description: Review prescribing trends for recipients prescribed opiates with a MME > 90** **Number of Exceptions Per Problem Type: 259 recipients; 659 claims** **Results of RetroDUR Screening and Interventions: The DUR Board moved to amend and expand the soft edit from targeting recipients on > 300 MME to recipients on > 50 MME based on a single or accumulation of opiate claims.** **9. Exception Period Covered by Run: 02/02/2019-05/02/2019** **Problem Type Description: Safety** **Criteria Description: To determine pre and post impact of deployment of the maximum dose of antidepressants in children >/= 6 years of age** **Number of Exceptions Per Problem Type: 14 recipients** **Results of RetroDUR Screening and Interventions: The DUR Board reviewed the post impact data and decline in claims for recipients exceeding the antidepressant FDA prescribing limits. The DUR Board requested follow up on recipients exceeding the limits.** **10. Exception Period Covered by Run: 03/07/2019-06/07/2019** **Problem Type Description: Therapeutic Appropriateness** **Criteria Description: To determine pre and post impact of deployment of the polypharmacy in TNF inhibitors edit** **Number of Exceptions Per Problem Type: 699 claims** **Results of RetroDUR Screening and Interventions: The DUR Board reviewed the post impact data and significant decline in claims (100% decline) on polypharmacy in TNF inhibitors.**

Section IV - DUR BOARD ACTIVITY

Question	Response
1. Summary 3 – DUR Board Activities Report. Summary 3 DUR Board Activities Report should be a brief descriptive report on DUR Board activities during the fiscal year reported.	**Summary of DUR Board Activities** **The Drug Utilization Review (DUR) Board reviews and approves drug use criteria and standards for both prospective and retrospective drug use reviews. It applies these criteria and standards in the application of DUR activities. The goal of the Florida Medicaid DUR program is to promote appropriate prescribing and use of medications.** **Magellan Medicaid Administration's ProDUR system is an integrated component of the online, real-time point of sale (POS) system. It compiles both medical and pharmacy claims data into comprehensive online beneficiary health summaries. Pharmacy claims are evaluated according to approved criteria against each member's summary. Claims history includes current, historical, paid, and denied claims data, regardless of the media source of the claims submission. The real-time evaluation of POS claims permits identification of drug therapy problems prior to dispensing.** **The RetroDUR utilization analyses, as described below, provides information which assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians to potential drug therapy problems, identifies opportunities to improve drug therapy and makes recommendations to avoid drug therapy problems.** **The ongoing operation of the RetroDUR program is a shared responsibility of Magellan Medicaid Administration, a Magellan Medicaid Administration Company, and the Agency for Health Care Administration (Agency). Each quarter, specific therapeutic areas that have been approved by the DUR Board are targeted for focused review under the RetroDUR program. Magellan Medicaid Administration applies the specified criteria established by the Board to the prescription and health claims files and identifies medication regimens that violate the criteria. Results of analyses are provided to the Board during quarterly meetings. Electronic educational**

Question	Response
	letters are created by Magellan Medicaid Administration, regarding targeted criteria. Letters are reviewed and approved by the DUR Board and the Agency. The electronic letters are posted to a designated provider alert area of the Agency's website for the provider community. (http://ahca.myflorida.com/medicaid/Prescribed_Drug/banners.shtml). **With enhanced technology, Magellan Medicaid Administration offered the DUR Board the ability to provide recommendations to the Agency for POS edits to assist in the mission of the Board, which include educating physicians and positively impacting prescribing for Florida Medicaid recipients. The DUR Board reviews the potential edits and makes recommendations based on their clinical expertise and knowledge. DUR Board members frequently collaborate with colleagues regarding drug utilization issues and bring the results of those discussions back to the DUR Board for consideration.** **The Florida Medicaid DUR Board met four times during the Federal Fiscal Year 2019. During this timeframe, Magellan Medicaid Administration recommended RetroDUR criteria associated with drug to drug interactions, inappropriate dosing, therapeutic duplication, polypharmacy, safety precautions and overutilization of medications.** **Magellan Medicaid Administration produces a monthly newsletter/Clinical Alert to educate the provider community about the most recent issues in the pharmaceutical industry and new drug information. These newsletters are available on the Magellan Rx Management website and can be accessed at: https://www1.magellanrx.com/magellan-rx/publications/pharmacy-clinical-alerts.aspx** **Summary of DUR Board activities:** **Review the top 20 therapeutic classes by claims volume and expenditure.** **Review asthma recipients on inhaled corticosteroid monotherapy without receiving rescue therapy.** **Continued review of recipients on Long**

Question	Response
	Acting Injectable Antipsychotics (LAI AP) to assess compliance and rationale for non-compliance. **The DUR Board reviewed LAI AP utilization in children less than 18 years of age.** **Review of recipients on oral antipsychotic therapy concomitantly with injectable antipsychotic therapy. The DUR Board voted to create a hard edit denying the oral antipsychotic if a recipient has been on concomitant therapy for over 90 days.** **Review of recipients utilizing two or more oral antipsychotic therapies. The DUR Board voted to implement an edit to limit a recipient to two antipsychotics of the different chemical entities.** **Review concomitant use of opiates and antipsychotic therapy. In response to the Support Act, a soft edit was deployed for recipients on concomitant therapy.** **Review recipients with overlapping claims for both an opioid and a benzodiazepine. An education campaign indicating the Centers for Disease Control and Prevention (CDC) recommendation followed by a soft message to pharmacies regarding the interaction. A follow-up analysis 6 months after deployment was reviewed. The DUR Board voted to create a hard edit denying concomitant therapy at the POS following a provider educational campaign.** **Review utilization of opiates and Narcan (naloxone).** **Review recipients who had claims deny due to the morphine milligram equivalent (MME) hard edit for recipients that are treatment naive to opiate therapy. The DUR Board voted to create a soft edit on recipients with MME>50 based on a single or accumulation of opiate claims.** **Review utilization of opiate containing cough and cold preparation in children. The DUR Board voted to change age minimum to 18 years of age following the FDA safety alert recommendations.** **Review utilization of oral codeine medication in children younger than 12 years of age. The DUR Board voted to change the age minimum from 6 years of age to 12 years of age**

Question	Response
	following the FDA safety alert recommendations. **Review non-benzodiazepine sedative utilization and concomitant use with opiates. The DUR Board voted to create a hard edit for concomitant therapy.** **Assessment of hepatitis C medication utilization and retreatment. Review of adolescent utilization of hepatitis C therapy.** **Review recipients with overlapping claims for both a benzodiazepine and a stimulant medication due to the drug interaction and opposing pharmacologic actions. Edit deployed to deny claim requiring DUR intervention codes for claims to adjudicate. The DUR Board reviewed the post impact analysis of soft edit and voted to move to a hard edit denial.** **Review recipients with overlapping claims for both a non-benzodiazepine sedative and a stimulant medication.** **Review recipients over 6 years of age who were receiving doses of an antidepressant medication which exceeded the recommended maximum daily dose. The DUR Board approved implementation of maximum daily dose/quantity limits on this class of medications for all patients.** **Review recipients utilizing more than one DPP-4 inhibitor, GLP-1 agonist, or the two concomitantly. The DUR Board voted to implement a therapeutic duplication edit. This edit will deny claims if recipients are utilizing more than one DPP-4 or more than one GLP-1 or a combination of both within 90 days.** **Review recipients initiating zolpidem therapy at higher doses than the FDA recommended starting dose of 5mg immediate release (IR) and 6.25mg extended release (ER). The DUR Board voted to extend the lower dose step therapy to both genders as a safety precaution. The intervention will prohibit use of 10mg or 12.5mg zolpidem, then look back 90 days for 5mg or 6.25mg for at least a 24-day supply.** **Review recipients identified as using polypharmacy in tumor necrosis factors (TNF). The DUR Board recommended the**

Question	Response
	implementation of a therapeutic duplication edit across the classes of biologics, non-biologics, and oral therapy. **The DUR Board reviewed Chantix utilization, adherence to the full course of therapy and updated the criteria to include non-pharmacologic smoking cessation therapy.** **The DUR Board reviewed appropriate utilization of selected topical medications and reviewed off-label use. The DUR Board voted to implement an automated prior authorization on all formulations of Calcipotriene for age, diagnosis, and duration of therapy and the DUR Board voted to create an automated prior authorization for Doxepin 5% cream to include diagnosis.** **The DUR Board reviewed therapeutic duplication among a select group of therapeutic classes. The DUR Board voted to create a therapeutic duplication edit for statin and long acting insulin therapeutic classes.** **The DUR Board reviewed utilization of anticonvulsants for seizure diagnoses and neuropathy diagnoses. The DUR Board reviewed Epidiolex utilization and FDA approved diagnosis in patient health conditions history. The DUR Board analyzed anticonvulsant use based on product specific FDA approved indications.** **The DUR Board reviewed HIV therapy to determine the average length of overlap for recipients transitioning from single ingredient HIV therapy to an equivalent combination product.** **Review utilization and compliance to Xolair.** **Review utilization and availability of biosimilar therapy.** **Review utilization of Xofluza.** **The DUR Board reviewed pancreatic enzyme utilization based on FDA approved indications. The DUR Board voted to implement an automated prior authorization including a FDA diagnosis look back.** **Review utilization trends for novel therapy.** **Review utilization of Lyrica and percent recipients with prior trial of gabapentin in claims history.** **The DUR board reviewed concomitant**

Question	Response
	utilization of gabapentin and opiates. **Summary of additions/deletions to DUR Board approved criteria:** **Amend the Chantix criteria to include documentation of non-pharmacologic smoking cessation therapy:** **Create an automated prior authorization for Calcipotriene and Doxepin topical therapy;** **Create an automated prior authorization for pancreatic enzymes to include the FDA approved indication for treatment:** **Reviewed novel therapy criteria including Spinraza, Exondys 51, Zolgensma, Luxturna, Yescarta, and Kymriah.**
2. Does your state have an approved Medication Therapy Management Program?	**Yes**
a. Have you performed an analysis of the program's effectiveness?	**Yes**
"Yes," please provide a brief summary of your findings.	The findings of the Medication Therapy Management research team have been used to support DUR board edits and activities.
b. Is your DUR Board involved with this program?	**No**
If the answer to question 2 is "No," are you planning to develop and implement a program?	N/A

Section V - PHYSICIAN ADMINISTERED DRUGS

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

Question	Response
1. ProDUR?	**Yes**
If "No," do you have a plan to include this information in your DUR criteria in the future?	N/A
2. RetroDUR?	**Yes**
If "No," do you have a plan to include this information in your DUR criteria in the future?	N/A

Section VI - GENERIC POLICY AND UTILIZATION DATA

Question	Response
1. Summary 4 – Generic Drug Substitution Policies Summary 4 Generic Drug Substitution Policies summarizes factors that could affect your generic utilization percentage. Please explain and provide details.	**Florida Medicaid Pharmacy Program** **Drug Utilization Review Annual Report: FFY19** **Generic Drug Substitution Policies** **Florida Medicaid has a prescribed-drug spending-control program that includes the Medicaid preferred drug list (PDL). The PDL is a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee. The primary goal of this Committee is to ensure availability of medications that are safe, efficacious, and cost-effective, via the PDL, to Florida Medicaid recipients.** **In many cases, generic drug utilization is encouraged as the most suitable medication for recipients. The Florida Agency for Health Care Administration is authorized to seek any federal waivers necessary to implement cost-control programs and to continue participation in the federal Medicaid rebate program. Due to the participation in the federal and supplemental rebate program, occasionally Florida Medicaid is afforded the opportunity to realize more cost savings when a branded product is dispensed versus the generic counterpart. In those instances, the branded product is included on the PDL and the generic is excluded. Florida Medicaid also promotes generic substitution through point of sale edits such as requiring a clinical prior authorization for any branded drug for which there is a generic available and implementation of a maximum allowable cost (MAC) program. Florida Medicaid continues to encourage generic substitution when possible. This is demonstrated by Florida Medicaid's generic utilization rate of 79% for Federal Fiscal Year 2019.**
2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your state have a more restrictive requirement?	**No**
If "Yes," check all that apply.	N/A
Other, please explain.	N/A

Question	Response

Table 2 - Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	443,764	2,853,968	323,268
Total Reimbursement Amount Less Co-Pay	$735,567,202	$72,685,681	$175,249,376

Question	Response
3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Number of Generic Claims	2,853,968
Total Number of Claims	3,621,000
Generic Utilization Percentage	78.82%
4. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period using the computation instructions in Table 2 - Generic Drug Utilization Data.	
Generic Dollars	$72,685,681
Total Dollars	$983,502,259
Generic Expenditure Percentage	7.39%

Section VII - PROGRAM EVALUATION / COST SAVINGS / COST AVOIDANCE

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

Question	Response
If "Yes," identify, by name and type, the institution that conducted the program evaluation.	
Institution Type	Company
Institution Name	Magellan Medicaid Administration, Inc.
2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below	

	Data
ProDUR Total Estimated Avoided Costs	$337,535,420.00
RetroDUR Total Estimated Avoided Costs	$12,693,649.00
Other Cost Avoidance	$1,233,116.00
Grand Total Estimated Avoided Costs	$351,462,185.00

Question	Response
3. The Estimated Percent Impact was generated by dividing the Grand Total Estimated Avoided Costs from Question 2 above by the Total Dollar Amount provided in Section VI, Question 4, then multiplying this value by 100. Estimated Percent Impact	**35.74%**
4. Summary 5 – Cost Savings/Cost Avoidance Methodology Summary 5 Cost Savings/Cost Avoidance Methodology includes program evaluations/cost savings estimates prepared by state or contractor.	**Florida Medicaid Pharmacy Program** **Drug Utilization Review Annual Report: FFY19** **Cost Savings/Cost Avoidance Methodology** **Maximum Allowable Cost** **The Maximum Allowable Cost (MAC) program establishes a maximum price per unit at which Florida Medicaid will reimburse pharmacy providers for generic medications. By using the MAC price, the Medicaid Program reimburses at the same rate for the included products. This enables pharmacy providers to select the agent that is most effective for them without disadvantaging the Medicaid Program.** **MAC program savings are calculated by re-pricing each claim that paid at MAC as if the MAC price had not existed at the point of adjudication. MAC savings is the difference**

	between the MAC price and the recalculated payment amount. During FFY 2019, the MAC program provided savings of $3,037,401. **Preferred Drug List (PDL)** **Supplemental rebates are collected from pharmaceutical manufacturers for their inclusion as a preferred product. Additionally, market shift savings are generated by shifting the market from more expensive, non preferred products, to less expensive, preferred products. The total savings provided by the PDL program during FFY 2019 was $5,391,401.** **Retrospective DUR** **For all edits or criteria approved by the DUR Board, a pre-implementation analysis is conducted demonstrating the number of claims, number of recipients, and total amount paid that would be impacted by such an edit or criteria. At a reasonable amount of time after implementation of the edit or criteria, a post-implementation analysis is performed demonstrating the number of claims, number of recipients and total amount paid for a similar period of time. The standard post implementation analysis is conducted three months after deployment of the edit but may vary depending on the nature of the edit and the time needed to measure an impact. For example, if an edit allows for a six month window before claims denial, the impact of the edit would not be assessed until approximately nine months after the edit is deployed. The cost savings is considered to be the difference in the total amount paid between the pre-implementation and the post-implementation. These figures are then annualized to calculate the RetroDUR cost savings impact. The total savings measured at the time of report submission for RetroDUR edits in FFY2019 was $12,693,649.20.** **Prospective DUR-** **ProDUR cost avoidance for the Florida Medicaid prescription drug program is the sum of the claims that were reversed or denied and not resubmitted. The ProDUR cost avoidance for FFY 2019 was $337,535,420. The following table**

	summarizes the FFY 2019 data. However, cost avoidance should not be interpreted as true cost savings. While the ProDUR edit may have resulted in a claim reversal or denial, it is not known what the complete impact this has on the program. There are many prescriptions that are switched after point of sale to alternative medications, which would have an improved therapeutic benefit to the patient and would not generate a ProDUR edit. The cost of this alternative medication is not reflected in the calculation of ProDUR cost avoidance. Another factor that influenced this calculation was multiple claim submission for an individual recipient's prescription. This would result in a number of claims and ProDUR edits for one prescription. If the provider fails to reverse the various claims, the calculations would be inflated.

Section VIII - FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

Question	Response
1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Deny claims and require prior authorization, Other
"Other," Please explain	Deny claims and require a prospective drug utilization review by the pharmacist at the point of sale.
2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances? If the answer to question 2 is "Yes," please continue	**No**
a. What criteria does your state use to identify candidates for Lock-In? Check all that apply:	**N/A**
"Other," please explain	N/A
b. Do you have the capability to restrict the beneficiary to:	

Question	Response
i. Prescriber only	**N/A**
ii. Pharmacy only	**N/A**
iii. Prescriber and Pharmacy	**N/A**
c. What is the usual Lock-In time period?	**N/A**
"Other," please explain	N/A
d. On average, what percentage of the FFS population is in Lock-In status annually?	**N/A%**
e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review as part of Attachment 5.	**$N/A**
3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Deny claims written by this prescriber, Refer to Program Integrity Unit
"Other," please explain	N/A
"No," please explain	N/A
4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by pharmacy providers?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Deny claim, Other
"Other," please explain	Claims will deny that exceed the limits set by the Agency (i.e., Morphine Milligram Equivalent (MME), quantity limits, and day supply limits).
"No," please explain	N/A
5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by beneficiaries?	**Yes**
"Yes," please explain your program for fraud, waste, or abuse of non-controlled substances.	There are prescribing limits (i.e., quantity limits, duration of therapy) on non-controlled drugs based on FDA prescribing guidelines and package inserts.
"No," please explain	**N/A**

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

Question	Response
1. Does your state have a Prescription Drug Monitoring Program (PDMP)? If the answer to question 1 is "Yes," please continue with a, b, and c.	**Yes**
a. Does your agency have the ability to query the state's PDMP database? If the answer to sub-question 1 a is "Yes," please continue.	**No**
i. Please explain how the state applies this information to control fraud and abuse.	N/A
ii. Do you also have access to Border States' PDMP information?	N/A
iii. Do you also have PDMP data (i.e. outside of MMIS, such as a controlled substance that was paid for by using cash) integrated into your POS edits?	N/A
b. Do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing controlled substances?	**Yes**
c. Are there barriers that hinder the agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?	**Yes**
"Yes," please explain the barriers (i.e. lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).	Medicaid does not have access to PDMP.
2. Have you had any changes to your state's Prescription Drug Monitoring Program during this reporting period that have improved the agency's ability to access PDMP data?	**No**
"Yes," please explain.	N/A

C. PAIN MANAGEMENT CONTROLS

Question	Response
1. Does your program obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs? If the answer to question 1 is "Yes," please continue.	**No**

Question	Response
a. Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?	**N/A**
If "Yes," please explain how information is applied.	N/A
If "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?	N/A
If "No," please explain	N/A
b. Do you apply this DEA file to your RetroDUR reviews?	**N/A**
If "Yes," please explain how it is applied.	N/A
2. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?	**Yes**
If "No," please explain why you do not have a measure in place to either manage or monitor the prescribing of methadone for pain management.	N/A

D. OPIOIDS

Question	Response
1. Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription? If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue.	**Yes, for all opioids**
Please explain answer above.	For opioid treatment naive recipients, the limit is 90 MME. There are also product specific limits per FDA package inserts.
a. Is there more than one quantity limit for the various opioids?	**Yes**
"Yes," please explain	For opioid treatment naive recipients, the limit is 90 MME. There are also product specific limits per FDA package inserts.
b. What is the maximum number of days' supply allowed for an initial opioid prescription?	**14**
c. Does this days' supply limit apply to opioid prescriptions?	**Yes, for some opioids**
"No," please explain	N/A

Question	Response
2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?	**Yes**
If "Yes," what is your maximum days' supply per prescription limitation?	Other
"Other," please explain	Schedule II Short Acting (SA) Narcotics: Max of 3-day supply and 2 fills per month. If "Acute Pain Exemption" on prescription Max of 7-day supply and 2 fills per month. Schedule III-V SA Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 Long Acting (LA) Narcotic every 30 days.
If "No," please explain	N/A
3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids?	**Yes**
If "Yes," what is your maximum days' supply per prescription limitation?	30 day supply
"Other," please explain	N/A
If "No," please explain	N/A
4. Do you have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?	**Yes**
If "Yes," check all that apply:	Deny claim and require PA, Intervention letters, Morphine Milligram Equivalent (MME) daily dose program, Step therapy or clinical criteria, Requirement that prescriber has an opioid treatment plan for patients, Require PDMP checks
Please provide details on these opioid prescribing controls in place.	Schedule II Short Acting (SA) Narcotics: Max of 3-day supply and 2 fills per month. If "Acute Pain Exemption" on prescription Max of 7-day supply and 2 fills per month. Schedule III-V SA Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 Long Acting (LA) Narcotic every 30 days. Opioid prescribing trends and potential fraud and/or abuse are identified via automated claims review by the DUR Board. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.	N/A

Question	Response
5. Do you have POS edits to monitor duplicate therapy of opioid prescriptions?	**Yes**
Please explain	Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 LA Narcotic every 30 days.
6. Do you have POS edits to monitor early refills of opioid prescriptions dispensed?	**Yes**
Please explain	The early refill percent threshold is set at 90% for opioid prescriptions.
7. Do you have comprehensive claims review automated retrospective process to monitor opioid prescriptions exceeding these state limitations?	**Yes, please explain in detail scope and nature of these retrospective reviews**
Please explain	Opioid prescribing trends and potential fraud and/or abuse are identified via automated claims review by the DUR Board. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
8. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and benzodiazepines being used concurrently?	**Yes, both POS edits and retrospective reviews**
If "Yes," Please explain in detail scope and nature of reviews and edits.	A soft edit to deny all prospective drug utilization review (ProDUR) therapeutic duplication (TD) and drug to drug interaction (DD) edits for any benzodiazepine and opioid combinations. The DUR Board did a retrospective review of the soft edit and voted to move to a hard edit to be deployed in FFY20.
If "No," Please explain	N/A
9. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and sedatives being used concurrently?	**Yes, retrospective reviews only**
If "Yes," Please explain in detail scope and nature of reviews and edits.	**The DUR Board did a retrospective review of concomitant use of non-benzodiazepine (Non-BZD) sedatives and opioids. The DUR Board voted to create a hard edit for recipients on concomitant therapy. The edit will start with the Non-BZD sedative treatment naive recipients. Treatment naive is defined by the recipient having no paid claims for Non-BZD in the prior 60 days. An additional 2 month soft edit will be provided**

Question	Response
	for Non-BZD sedative treatment experienced recipients with POS messaging advising the third fill of concomitant therapy will deny for a prior authorization. The prior authorization would be required for the Non-BZD sedative only. The hard edit includes long acting opiates only to allow for acute treatment of pain with short acting opiates. Seizure recipients, cancer/palliative care, Sickle Cell and Long-Term Care Facility (LTCF) recipients are excluded from the hard edit. The edit is to be deployed in FFY20.
If "No," Please explain	**N/A**
10. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and antipsychotics being used concurrently?	**Yes, both POS edits and retrospective reviews**
If "Yes," Please explain in detail scope and nature of reviews and edits.	The DUR Board did a retrospective review of concomitant use of opioids and antipsychotics. In response to the SUPPORT Act, the Agency proceeded with deployment of a soft edit for individuals prescribed opioids and antipsychotics concomitantly. The pharmacist will have the capability to enter approved DUR intervention codes to allow claim payment. Cancer, Sickle Cell and LTCF recipients will be excluded from the edit.
If "No," Please explain	N/A
11. Do you have POS safety edits or perform RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?	**Yes, both POS edits and retrospective reviews**
If "Yes," retrospective reviews are performed, please indicate how often.	Quarterly
"Other," please specify.	N/A
Please explain nature and scope of edits, reviews and/or provider education reviews performed.	Opioid prescribing trends and potential fraud and/or abuse are identified via automated claims review by the DUR Board. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
If "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?	N/A
If "No," Please explain.	N/A

Question	Response
12. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?	**Yes**
If "Yes," please check all that apply	Your state Medicaid agency refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain.
Please identify the "other" guidelines.	N/A
Please explain why no guidelines are offered.	N/A
13. Do you have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?	**Yes**
"Yes," please explain	To receive an abuse deterrent opioid system requires recipients to have 2 fills of a SA Narcotic within 75 days plus a fill of Embeda within 60 days OR a fill of any Abuse Deterrent Narcotic (ADN) within 60 days to receive an ADN.

E. MORPHINE MILLIGRAM EQUIVALENT (MME) DAILY DOSE

Question	Response
1. Have you set recommended maximum MME daily dose measures?	**Yes**
If "Yes," please continue	
a. What is your maximum morphine equivalent daily dose limit in milligrams?	**90 MME mg per day**
i. If "Other", please specify	**N/A mg per day**
b. Please explain nature and scope of dose limit.	**Applies only to treatment naive recipients defined as not receiving opioid prescriptions in previous 60 days. An edit for all opioid recipients is set to deploy in FFY20.**
If "No," please explain the measure or program you utilize.	**N/A**
2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?	**Yes**
a. If "Yes," Please name the developer of the calculator:	**CDC**
If "Other," please specify	N/A

Question	Response
b. If "Yes," how is the information disseminated? Check all that apply:	**Provider notice**
If "Other," please explain	N/A
3. Do you have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?	**Yes**
If "Yes," do you require prior authorization if the MME limit is exceeded?	Yes
4. Do you have automated retrospective claim reviews to monitor total daily dose (MME) of opioid prescriptions dispensed?	**Yes**
Please explain	The retrospective claim review to monitor total daily dose (MME) of opioid prescriptions is reviewed by the DUR Board quarterly.

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER (OUD)

Question	Response
1. Does your agency set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?	**Yes**
If "Yes," please specify the total mg/day:	24 mg
If "Other," please explain	N/A
2. What are your limitations on the allowable length of this treatment?	**No limit**
If "Other," please explain	N/A
3. Do you require that the maximum mg per day allowable be reduced after a set period of time? If "Yes," please continue	**No**
a. What is your reduced (maintenance) dosage?	**N/A**
If "Other," please explain	N/A
b. What are your limitations on the allowable length of the reduced dosage treatment?	**N/A**
If "Other," please explain	N/A
4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?	**Yes**

Question	Response
5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?	**No**
"Other," please explain	N/A
If "Yes," can the POS pharmacist override the edit?	N/A
6. Do you have at least one naloxone opioid overdose product available without prior authorization?	**Yes**
7. Do you retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?	**Yes**
Please explain	Opioid prescribing trends and potential fraud and/or abuse are identified via automated claims review by the DUR Board. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
8. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?	**Yes, State Board of Professional Regulations/Board of Pharmacy/ Board of Medicine and/or State Medicaid agency under protocol**
9. Does your state agency cover methadone for a substance use disorder (i.e. Methadone Treatment Center)?	**Yes**

G. ANTIPSYCHOTICS / STIMULANTS

ANTIPSYCHOTICS

Question	Response
1. Do you currently have restrictions in place to limit the quantity of antipsychotics?	**Yes**
Please explain	There are limits according to FDA package inserts.
2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?	**Yes**

Question	Response
a. If "Yes," do you either manage or monitor:	**All children**
"Other," please explain	N/A
b. If "Yes," do you have edits in place to monitor (check all that apply):	**Child's age, Dosage, Indication, Polypharmacy**
"Other" Please explain	N/A
c. Please briefly explain the specifics of your antipsychotic monitoring program(s).	**The clinical pharmacist is required to review submissions for all children under six and select children over six depending on antipsychotic selection and dosage.**
d. If "No," do you plan on implementing a program in the future?	**N/A**
If "Yes," when do you plan on implementing a program?	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.	N/A

STIMULANTS

Question	Response
3. Do you currently have restrictions in place to limit the quantity of stimulants?	**Yes**
4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?	**Yes**
a. If "Yes," Do you either manage or monitor:	**All children**
"Other," please explain	N/A
b. If "Yes," Do you have edits in place to monitor (check all that apply):	**Child's age, Dosage, Indication, Polypharmacy**
"Other," please explain	N/A
c. Please briefly explain the specifics of your documented stimulant monitoring program(s).	**High dose limitations are placed on all stimulants. A close prior authorization review is performed on all children less than six.**
d. If "No," do you plan on implementing a program in the future?	**N/A**
If "Yes," when do you plan on implementing a program?	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children	N/A

Section IX - INNOVATIVE PRACTICES

Question	Response
1. Summary 6 – Innovative Practices Summary 6 - Innovative Practices should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing).	**Florida Medicaid Pharmacy Program** **Drug Utilization Review Annual Report: FFY19** **Innovative Practices Narrative** **The point-of-sale (POS)/prospective drug utilization review (ProDUR) system provides the Florida Agency for Health Care Administration (Agency) with the ability to meet an important objective; that is, to minimize potential drug interactions and drug-induced illness or side effects. Adverse reactions from drugs occur more frequently when a recipient visits more than one physician and/or more than one pharmacy to obtain medication. Averting adverse drug effects may result in the prevention of subsequent physician visits, hospitalizations, or additional drug therapy. Magellan Medicaid Administration has brought this technology to the Drug Utilization Review (DUR) Board which allows the Board to make recommendations for edits to address the therapeutic appropriateness of drug regimens to the Agency for implementation via the POS system. These system edits encourage providers to prescribe medications appropriately, which is the primary goal of this Board.** **The Agency continues to automate many prior authorizations. Automated prior authorizations (AutoPA's) look for information in the patient's clinical record such as historic ICD-9 codes or current ICD-10 codes or CPT codes that may be a diagnosis marker and provides the ability to systematically make a decision whether to deny or pay claims during adjudication. AutoPA's may also look for a drug or a drug combination in the patient's clinical records/drug history to pay or deny claims. In addition, AutoPA's may also include a review of submitted claims data, pharmacy information, prescriber information, number of pharmacies in a patient history or number of prescribers in history, accumulated drug days supply, accumulated dose and**

Question	Response
	accumulated drug quantities. **The DUR Board works collaboratively with the Pharmaceutical and Therapeutics (P&T) Committee to ensure Florida Medicaid recipients receive optimized drug therapy. The DUR Board makes recommendations for the P&T Committee to consider and the P&T Committee will frequently refer utilization questions to the DUR Board for follow up. A report from the other Committee is a standing agenda item at each of these meetings.**

Section X - E-PRESCRIBING

Question	Response
1. Does your MMIS or pharmacy vendor have a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?	**Yes**
If "Yes," do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?	Yes
If "Yes," please explain the evaluation methodology. **Summary 7 –E-Prescribing Activity** should explain the evaluation methodology utilized in evaluate the effectiveness of providing drug information and medication history prior to prescribing.	Florida Medicaid Pharmacy Program Drug Utilization Review Annual Report: FFY19 E-Prescribing Activity Summary In 2007, the Florida Legislature implemented electronic prescribing (e-prescribing), pursuant to Section 408.0611, Florida Statutes, (F.S.). The law states the following : Florida Statutes, 408.0611 Electronic prescribing clearinghouse. (1) It is the intent of the Legislature to promote the implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies in order to prevent prescription drug abuse, improve patient safety, and reduce unnecessary prescriptions. To that end, it is the intent of the Legislature to create a clearinghouse of information on electronic prescribing to convey the process and advantages of

Question	Response
	electronic prescribing; to provide information regarding the availability of electronic prescribing products, including no-cost or low-cost products; and to regularly convene stakeholders to assess and accelerate the implementation of electronic prescribing. (4) Pursuant to s. 408.061, the agency shall monitor the implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies. By January 31 of each year, the agency shall report on the progress of implementation of electronic prescribing to the Governor and the Legislature. Information reported pursuant to this subsection shall include federal and private sector electronic prescribing initiatives and, to the extent that data is readily available from organizations that operate electronic prescribing networks, the number of health care practitioners using electronic prescribing and the number of prescriptions electronically transmitted. On July 1, 2010, the Florida Agency for Health Care Administration (Agency) implemented the participation of Florida Medicaid in the Surescripts pharmacy network enabling providers to access Florida Medicaid prescription drug claims data using any Surescripts certified e-prescribing tool. The data feed is real time, and provides recipient eligibility status, preferred drug information, plan limitations, and medication histories. The Agency's objective is to prevent medication errors and curb prescription fraud and abuse by giving providers actionable information at the time of prescribing. The Magellan Medicaid Administration e-prescribing program supports a model for recipient demographics, eligibility, and medication history. Magellan Medicaid Administration sends recipient eligibility, medication history files to SureScripts/RxHub weekly. Program capabilities include: Prescriber requests for recipient eligibility using an ASC X12 270 format. SureScripts/RxHub will validate the

Question	Response
	transaction format and locate the recipient based on Magellan Medicaid Administration's demographics file and unique identifiers of the recipient to determine if the requested recipient information is housed and available. SureScripts/RxHub responds back to the requesting prescriber with the recipient's eligibility response (ASCX12 271). Prescriber requests for recipient medication history from SureScripts/RxHub using the NCPDP SCRIPT 8.1 format. This request can be limited to specific date ranges, or if no date is entered, defaults to the entire drug history (a rolling maximum of 13 months) for the recipient. SureScripts/RxHub validates the recipient elements on the request against a stored PBM dataset. Magellan Medicaid Administration supplies the recipient medication history and SureScripts/RxHub completes interaction/DUR checks. The recipient medication history from Magellan Medicaid Administration is routed to the requesting prescriber through SureScripts/RxHub. The transaction activity of the e-prescribing program is routinely monitored. SureScripts/RxHub provides monthly reports of the number of inquiries for eligibility, medication history and formulary. In addition, Magellan Medicaid Administration provides daily and monthly reports of the prescribers that are using the application. The Agency provides a single point of access for e-prescribing information referred to as the Florida Electronic Prescribing Clearinghouse. It is designed to meet the requirements of Section 408.0611, F.S., and provides information on developments and trends in e-prescribing in the state. The website contains annual e-prescribing reports as well as quarterly metrics on the status of e-prescribing adoption in Florida. , Selected metrics from these reports for 2019 include the following: Through the 3rd quarter of 2019, there were an average of 10, 879,800 electronic

Question	Response
	prescriptions per month. The number of Medicaid medication record requests (for specific patient information such as eligibility, benefits or medication history) averaged 505,420 per month for the first 3 quarters of 2019. This was an increase from 2018 when the number of Medicaid medication requests averaged 439,713 per month. The annual e-prescribing rate increased 75.9% from 1.6% of Florida prescriptions in 2007 to 77.5% as of the 3rd quarter of 2019. The percentage of health care professionals who are e-prescribing (e-prescribers) at the end of the 3rd quarter of 2019 was 73.9%. This figure demonstrated an increase of 1 percentage point compared to prior quarter. Reference: 1Online Sunshine, Official Internet Site of the Florida Legislature. The 2019 Florida Statutes, 408.0611 Electronic prescribing clearinghouse. Available at: http://www.leg.state.fl.us/STATUTES/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0408/Sections/0408.0611.html Accessed: January 8, 2020. Agency for Health Care Administration Florida's Annual Electronic Prescribing Reports, Florida ePrescribing Report 2019 Available at: https://ahca.myflorida.com/SCHS/ePrescribing/docs/Florida2019ePrescribeReport.pdf Accessed: February 13, 2020. Agency for Health Care Administration ePrescribing Dashboard. Quarterly Metrics Summary and Data Charts 2019. Available at: https://ahca.myflorida.com/SCHS/ePrescribing/docs/2019eprescribemetrics3Q.pdf Accessed: January 8, 2020.
If “No,” are you planning to develop this capability?	N/A
If “No,” please explain	N/A
2. Does your system use the NCPDP Origin Code that indicates the prescription source?	**Yes**

Section XI - MANAGED CARE ORGANIZATIONS (MCOs)

Question	Response
1. How many MCOs are enrolled in your state Medicaid program?	**16**
2. Is your pharmacy program included in the capitation rate (carved in)?	**Partial**
If "Partial," please specify the drug categories that are carved out.	Hemophilia (Spinraza and Exondys are billed by the MCO plans as of 01/01/19)
3. Does the state set requirements for the MCO's pharmacy benefit (e.g. same PDL, same ProDUR/RetroDUR)?	**Yes**
a. If "Yes," please check all requirements that apply	**Formulary Reviews, Same PDL, Same ProDUR, Same RetroDUR**
b. If "Yes," please briefly explain your policy.	**MCO plans criteria, edits, etc. cannot be more restrictive than the Agency.**
If "No," do you plan to set standards in the future?	N/A
If "No," please explain	N/A
4. Did all of your managed care plans submit their DUR reports?	**Yes**
If "No," please explain.	N/A

Section XII – EXECUTIVE REPORT

Question	Response
Summary 8-Executive Report should provide a brief overview of your program. It should describe 2019 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.	**Executive Summary** **Drug Utilization Review Program Overview** **Magellan provides electronic claims processing and a pharmacy claims management system incorporating on-line point-of-service (POS) and prospective drug utilization review (ProDUR) for the Florida Medicaid Fee-for-Service (FFS) Program. The primary objective of the ProDUR program is to improve the quality of care for recipients by reducing the potential for drug interactions as well as adverse drug reactions. Additional goals include conserving program funds and expenditures, as well as maintaining program integrity by controlling problems of fraud and benefit abuse.** **The operation of the retrospective drug utilization review (RetroDUR) program is a shared responsibility of Magellan and the Agency. The goal of the RetroDUR program is**

Question	Response
	to promote appropriate medication prescribing by identifying patterns of potentially inappropriate prescribing or medication use. Once these patterns are reviewed and studied, potential interventions to address the issue are presented to the DUR Board for consideration. An analysis of the impact of planned interventions is created and agreed upon interventions are then communicated to physicians and/or pharmacists to improve prescribing and patient outcomes. **Prospective Drug Utilization Review Program (ProDUR)** **ProDUR encompasses the detection, evaluation, and counseling components of predispensing drug therapy screening. The ProDUR system of Magellan assists the pharmacist in these functions by addressing nine different situations in which potential drug problems may exist. ProDUR is performed prior to dispensing and helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may have been previously unavailable. Because Magellan's ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. ProDUR recognizes that pharmacists utilize their education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid pharmacists in their professional duties. For certain edits, as determined by the DUR Board, ProDUR edits may be overridden by the pharmacist in such cases where the pharmacist, either alone, or in consultation with prescriber has determined the accuracy and safety of the prescription. To accomplish the override, the provider must input the Reason for Service, Professional Service and Result of Service Codes in the appropriate fields. In other situations, as deemed appropriate by the DUR Board, no override of the ProDUR edit can be accomplished at the POS and a prior authorization must be obtained before the**

Question	Response
	medication can be dispensed. This action adds an extra layer of safety in situations where the risks are known to be substantial or the prescribed therapy falls outside of nationally accepted standards of care. Magellan's ProDUR system assists the pharmacist with the detection, evaluation, and counseling components of pre-dispensing drug therapy screening by addressing nine drug therapy problem types in which potential medication problems may exist. The screening types identified by Florida Medicaid's FFS ProDUR criteria are: **Excessive Daily Dose (HD) Alert occurs when the calculated dose per day of a drug exceeds the recommended daily dosage. The criteria for excessive daily dose are age specific.** **Insufficient Daily Dose (LD) Alert occurs when the calculated dose per day of a drug is less than the minimum recommended daily dosage. The criteria for insufficient daily dose are age specific.** **Early Refill (ER) Alert occurs when a prescription is refilled before 80 percent of the previously filled prescription's days' supply has elapsed.** **Therapeutic Duplication (TD) Alert occurs when a drug that is to be dispensed is in the same therapeutic class as another drug filled within the previous six weeks.** **Drug-Drug Interactions (DD) Alert occurs when a drug that is to be dispensed may interact with a previously filled drug (within the previous six weeks) from any participating pharmacy. Alerts are sent to pharmacies only on the most clinically significant drug interactions.** **Ingredient Duplication (ID) Alert occurs when a drug that is to be dispensed shares a common ingredient with a previously filled drug from any pharmacy.** **Drug to Gender (SX) Drug to Gender alerts occur when the drugs with risks of harm to a particular gender, or drugs not indicated to a specific gender are being prescribed.** **Drug-Age Contraindication (PA) Drug Age Contraindication alerts occur when a drug is dispensed that is not recommended for use in the age group of the patient. Age alerts**

Question	Response
	can occur when the patient is too old for the given medication, is too young for the given medication, or is not within the recommended age range for this medication. Underutilization (LR) Underutilization alerts occur when patients have waited to refill their maintenance medications beyond the specified days' supply of the previous fill. **ProDUR Cost Savings** **ProDUR cost savings are calculated by tracking claims that receive ProDUR alerts to determine if the pharmacy providers dispensed these prescriptions. Cost savings are reported from the cost of claims generating an alert, which were reversed by the pharmacist and not dispensed, and on claims that denied and were not overridden.** **Retrospective Drug Utilization Review (RetroDUR)** **The goal of the Florida Medicaid FFS RetroDUR Program is to promote appropriate prescribing and medication use. The RetroDUR utilization analysis, as described below, provides information that assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians and pharmacists to potential drug therapy problems, identifies opportunities to improve drug therapy, and makes recommendations to avoid drug therapy problems.** **Utilization Analysis** **The operation of the retrospective drug utilization review (RetroDUR) program is a shared responsibility of Magellan and the Agency. The RetroDUR program examines patterns of drug therapy utilization to detect potentially inappropriate prescribing or to examine prescribing patterns that are outside the established standard of care based on national guidelines or accepted standards of practice. The RetroDUR review process emphasizes medication classes where there is high utilization and/or high risk associated with those classes of medications. Recent updates to standards of practice, in the form of published peer-reviewed guidelines, as well as important safety communications from the US Food and Drug Administration**

Question	Response
	(FDA) service are utilized to ensure timely reviews of important therapeutic issues affecting Florida Medicaid FFS recipients. Utilizing pharmacy claims history, medical claims history and diagnostic information captured on medical claims, Magellan is able to provide a robust analysis of utilization and identify areas of concern. These analyses are presented to the DUR Board quarterly, along with background information and details of currently accepted medical guidelines, to help guide recommendations for specific interventions or edits that may be appropriate to implement based on the RetroDUR findings. Impact analyses are performed regarding specific recommendations and the DUR Board is informed prior to the implementation of any such edits. A follow-up post edit implementation analysis is performed after a specified time interval and these results are presented to the DUR Board as well to ensure the intended outcomes of the edit are being met and resulting in improved quality of care for Florida Medicaid FFS recipients. Depending on the clinical situation, communication to prescribers and/or pharmacies may be accomplished through posting a banner message on the AHCA website or by direct mailings to specific providers who were identified as part of the RetroDUR process. Specific drug classes that will be reviewed at upcoming quarterly Pharmacy & Therapeutics (P & T) meetings are examined for recommendations by the DUR Board to serve the state collaboratively along with the members of the P & T committee. In this capacity, the DUR Board serves to provide advisory input to the P & T committee based on drug utilization patterns that are examined and reviewed as part of the RetroDUR process. **RetroDUR Cost Analysis** **The provision of high quality drug therapy not only results in improved patient health but may also result in program cost savings. It is important to quantify the effect of interventions on the cost of drug therapy. Magellan performs a post-edit**

Question	Response
	implementation analysis for all RetroDUR interventions. This analysis examines any changes in number of claims, number of recipients or potential cost savings that may have occurred as a result of the intervention. Cost savings may vary due to a variety of factors including the particular class of medication, the intervention selected, the lag time before the recipient's next physician visit when changes in drug therapy may occur or changing patient demographics. Some interventions based on RetroDUR review emphasize the need to increase spending on a particular class of medications in order to improve adherence. Improved adherence for many classes of medications has been shown to improve outcomes and lessen other, long-term medical expenditures. **RetroDUR initiatives in FFY 2019 demonstrated cost savings as documented below:** **Minimum age limit of 18 years of age on opiate containing cough and cold preparations: $98.48 savings.** **Minimum age limit of 6 years of age on oral codeine preparations: $1,205.24 savings.** **Zolpidem step therapy edit: $7,144.92 savings.** **Maximum daily dose in antidepressant therapy: $15,673.92 savings.** **Polypharmacy in Tumor Necrosis Factor (TNF) inhibitors: $12,669,526.64 savings.**