Colorado

Medicaid Fee-For-Service (FFS)

Federal Fiscal Year (FFY) 2022

Drug Utilization Review (DUR)

Annual Report

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Section I - Number of Beneficiaries

Question	Response
1. On a monthly average, how many of your State's Medicaid beneficiaries are enrolled in your State's Medicaid Fee-For-Service (FFS) program that have a pharmacy benefit?	1,399,988
2. On a monthly average, how many of your State's Medicaid beneficiaries are enrolled in managed care plan(s)?	159,074

Section II - Prospective DUR (ProDUR)

Question	Response
1. Indicate the type of your pharmacy point of service (POS) vendor.	Contractor
a. Vendor Name	Magellan Rx Management
b. Who processes the State's National Council for Prescription Drug Programs (NCPDP) transactions?	POS vendor is a separate Pharmacy Benefits Manager (PBM)
2. Identify your ProDUR table driven criteria source. This would be initial ratings such as drug to drug interactions, dose limits based on age and pregnancy severity (multiple responses allowed).	First Databank
If "Other," please specify.	N/A
3. When the pharmacist receives a ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?	Varies by Alert Type
If "Yes" or "Varies by Alert Type," check all that apply.	Other, Alerts can be overridden with standard professional codes
If "Other," please explain.	Selected ProDUR alerts may be overridden by pharmacists using standard professional codes.
4. Does your State receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail?	Yes
If "No," please explain.	N/A
a. How often does your State receive reports (multiple responses allowed)?	Ad hoc (on request)
If "Other," please explain.	N/A
b. If you receive reports, does your State follow up with those providers who routinely override with interventions?	Yes
If "Yes," by what method does your State follow up (multiple responses allowed)?	Refer to Program Integrity for Review
If "Other," please explain.	N/A

Question	Response
5. Early Refill	
a. At what percent threshold do you set your system to edit?	
i. Non-controlled drugs:	75%
ii. Schedule II controlled drugs:	85%
iii. Schedule III through V controlled drugs:	85%
b. For non-controlled drugs, when an early refill message occurs, does your State require a PA?	Yes
If "Yes" or "Dependent on medication or situation," who obtains authorization?	Pharmacist or Prescriber
If "No," can the pharmacist override at the POS?	N/A
c. For controlled drugs, when an early refill message occurs, does your State require a PA?	Yes
If "Yes," who obtains authorization?	Pharmacist or Prescriber
If "No," can the pharmacist override at the POS?	N/A
6. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your State's policy allow the pharmacist to override for situations such as (multiple responses allowed):	Other
If "Other," please explain.	Pharmacist overrides at the point of sale are not allowed for lost or stolen prescriptions or for vacation requests. However, pharmacists may contact the pharmacy call center to request authorization to override these edits.
7. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?	Yes
If "Yes," please explain your edit.	A cumulative total of 20 days is allowed over a 180-day period for non-mail order transactions.
If "No," does your State plan to implement this edit?	N/A

Question	Response
8. Does the State Medicaid program have any policy prohibiting the auto-refill process that occurs at the POS (i.e., must obtain beneficiary's consent prior to enrolling in the auto-refill program)?	No
9. Does your system have a diagnosis edit that can be utilized when processing a prescription?	Yes
If "Yes," please explain.	The pharmacy claims system can verify the presence of specific ICD-10 diagnosis codes contained within a member's electronic claims record as part of automated processing of pharmacy claims for designated drug products. The system is also capable of verifying specific ICD-10 diagnosis codes when manually entered in the POS system during pharmacy claims processing.
10. For drugs not on your Preferred Drug List (PDL), does your Medicaid program have a documented process (i.e., PA) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?	Yes
If "Yes," check all that apply.	Pharmacist or technician reviews, Automatic PA based on diagnosis codes or systematic review, Trial and failure of first or second line therapies, Other
If "Other," please explain.	Prescribers may submit a pharmacy prior authorization (PA) request to the State's PBM, 24 hours a day/7 days a week by phone, fax, or electronically. PA denials are eligible for expanded clinical review after the prescriber submits additional patient-specific documentation and/or clinical literature to support medical necessity. If the expanded review also results in a denial, a formal appeals process is available for both prescribers and members.
If "No," please explain why not.	N/A
a. Does your program provide for the dispensing of at least a 72-hour supply of a COD in an emergency situation?	Yes
If "Yes," check all that apply.	Other process
If "Other process," please explain.	Pharmacists or prescribers may call the Magellan pharmacy help desk to request an emergency override to dispense a 3-day supply of medication in an emergency situation.
If "No," please explain why not.	N/A

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

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

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level	Column 2 Top 10 Prior Authorization (PA) Requests by Drug Class	Column 3 Top 5 Claim Denial Reasons (i.e., Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD) and Age Edits (AE))	Column 4 Top 10 Drug Names by Amount Paid, report at generic ingredient level	Column 5 % of Total Spent for Drugs by Amount Paid (From data in Column 4, determine the % of Total Drug Spend)	Column 6 Top 10 Drug Names by Claim Count, report at generic ingredient level	Column 7 Drugs by Claim Count % of Total Claims (From data in Column 6, determine the % of Total Claims)
dextroamphetamine/ amphetamine	all other dermatologicals	prior authorization required	adalimumab	7.12%	albuterol	3.39%
tretinoin	amphetamine preparations	early refill: overuse precaution	elexacaftor/ tezacaftor/ ivacaftor	2.91%	gabapentin	2.41%
methylphenidate	opioid analgesics	plan limitations exceeded	bictegravir/ emtricitabine/ tenofovir	2.88%	dextroamphetamine / amphetamine	1.72%
clindamycin	miscellaneous	drug-drug interaction	dulaglutide	2.40%	fluticasone	1.66%
oxycodone	diabetic therapy	product/ service not covered - plan/ benefit exclusion	lurasidone	1.86%	sertraline	1.61%
lisdexamfetamin	psychostimulants - antidepressants		fluticasone/ salmeterol	1.75%	amoxicillin	1.60%
clindamycin/ benzoyl peroxide	ataractics-tranquilizers		buprenorphine/ naloxone	1.69%	levothyroxine	1.59%
dupilumab	non-opioid analgesics		insulin aspart	1.66%	bupropion	1.51%
rimegepant	cns stimulants		albuterol	1.59%	omeprazole	1.46%
dulaglutide	bronchiol dilators		etanercept	1.49%	trazodone	1.43%

Question	Response
12. Section 1927(g)(A) of the Social Security Act (the Act) requires that the pharmacist offer patient counseling at the time of dispensing. Who in your State has responsibility for monitoring compliance with the oral counseling requirement (multiple responses allowed)?	Medicaid Program
If "Other," please explain.	N/A

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.	Academic Institution
a. Identify, by name, your RetroDUR vendor.	The Regents of the University of Colorado, Skaggs School of Pharmacy
b. Is the RetroDUR vendor the Medicaid Management Information System (MMIS) fiscal agent?	No
c. Is the RetroDUR vendor the developer/supplier of your retrospective DUR criteria?	Yes
Please explain "Yes" or "No" response.	Initial draft criteria are developed each quarter by faculty at the University of Colorado Skaggs School of Pharmacy (the vendor) then finalized in collaboration with the State's clinical pharmacist team prior to DUR Board review.
d. Does your State customize your RetroDUR vendor criteria?	Yes
2. How often does your State perform retrospective practitioner-based education?	Quarterly
If "Other," please specify.	N/A
a. How often does your State perform retrospective reviews that involve communication of client-specific information to healthcare practitioners (multiple responses allowed)?	Quarterly
If "Other," please specify.	N/A
b. What is the preferred mode of communication when performing RetroDUR initiatives (multiple responses allowed)?	Newsletters or other non-direct provider communications, Mailed letters
If "Other," please specify.	N/A

3. Summary 1 – RetroDUR Educational Outreach	INTERVENTIONAL LETTERS
RetroDUR Educational Outreach should be a year-end report on retrospective screening and educational interventions. The summary should be limited to the most prominent problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed below.	Educational letters that contain patient-specific information are prepared and mailed to prescribers on a quarterly basis. These letters generally cover clinical topics such as high risk opioid prescribing, high risk benzodiazepine prescribing, and high risk psychotropic medication prescribing in children. During FFY 2022, nearly 3,800 interventional and educational letters were mailed to Colorado Medicaid prescribers.

FFY 2022 Q1 (Oct 1 to Dec 31, 2021) - TOTAL 953
251   Adult members with claims for 2 or more BZD for 90/180 days using most recent data files
83   Members less than 18 years of age with claims for 2 or more antipsychotics for greater than 45 days of the measurement quarter
297   Concomitant claims for an opioid plus BZD plus muscle relaxant in adults
322   Members with claims for at least 150 MME with no corresponding claim for naloxone in the previous 12 months

FFY 2022 Q2 (Jan 1 to Mar 31, 2022) - TOTAL 983
314   Adult members with claims for 2 or more BZD for 90/180 days using most recent data files
84   Members less than 18 years of age with claims for 2 or more antipsychotics for greater than 45 days of the measurement quarter
256   Concomitant claims for an opioid plus BZD plus muscle relaxant in adults
329   Members with claims for at least 150 MME with no corresponding claim for naloxone in the previous 12 months

FFY 2022 Q3 (Mar 31 to Jun 30, 2022) - TOTAL 849
259   Adult members with claims for 2 or more BZD for 90/180 days using most recent data files
100   Members less than 18 years of age with claims for 2 or more antipsychotics for greater than 45 days of the measurement quarter
223   Concomitant claims for an opioid plus BZD plus muscle relaxant in adults
267   Members with claims for at least 150 MME with no corresponding claim for naloxone in the previous 12 months |

FFY 2022 Q4 (Jul 1 to Sep 30, 2022) - TOTAL 1002

230   Adult members with claims for 2 or more BZD for 90/180 days using most recent data files

311   *NEW* -- Members less than 18 years of age with claims for 3 or more psychotropic medications (antidepressants, antipsychotics, anxiolytics, mood stabilizers and stimulants) for 30/90 days of the measurement quarter

216   Concomitant claims for an opioid plus BZD plus muscle relaxant in adults

245   Members with claims for at least 150 MME with no corresponding claim for naloxone in the previous 12 months

OTHER RetroDUR MONITORING ACTIVITIES

A new paragraph was added to specific RetroDUR educational outreach letters during the 4th quarter of 2021. The paragraph states 'Please note that information contained in this letter is intended to alert providers to potential pharmacotherapy issues and create opportunities for making medication adjustments when warranted. RDUR communications may represent situations in which a member has received medications from more than one prescriber.' The new text appears to have increased provider acceptance of RetroDUR mailings over time and also appears to have fostered a somewhat higher level of increased communication and collaboration among prescribers who are providing (or have provided) care to individual Medicaid members.

A report summarizing members with multiple claims for opioid prescriptions that total > 200 MME calculated as a daily dose averaged over a 30-day period, along with the associated prescribers, is produced and reviewed quarterly.

A report summarizing the number of children and adolescent beneficiaries receiving 3 or more stimulant medications for 30+ continuous days per quarter, along with the associated prescribers, is produced and reviewed quarterly (a new, recurring report as of July 2022).

DUR DIGITAL NEWSLETTERS

DUR newsletters were developed, posted online, and distributed by email to DUR Board members and other key stakeholders in December 2021 and June 2022. The current Colorado DUR newsletter library is available online at

	https://hcpf.colorado.gov/drug-utilization-review-board. DUR Newsletter clinical topics during FFY 2022 included: Cardiovascular risks associated with ADHD drugs in adults; Colorado Medicaid hemophilia research module findings; Utilization management of physician administered drugs (PADs); New aspirin guidelines for primary prevention of cardiovascular disease; Cardiovascular risks associated with cannabis use; Involvement of gabapentin in fatal drug overdoses

Section IV - DUR Board Activity

Question	Response
1. Does your State have an approved Medication Therapy Management (MTM) Program?	Yes

2. Summary 2 – DUR Board Activities
 	
DUR Board Activities Summary should be a brief descriptive on DUR activities during the fiscal year reported.
	Number of DUR Board meetings held:
	Four virtual DUR Board meetings were held during FFY 2022: November 9, 2021; February 11, 2022; May 10, 2022; August 9, 2022
	
	Summary of additions/deletions to DUR Board reviewed criteria (including problem type/drug combinations added or deleted for ProDUR and therapeutic categories added or deleted for RetroDUR):
	
	November 9, 2021 Summary:
	-- New therapeutic classes added to the PDL: Oral Human Immunodeficiency Virus (HIV) Agents (although agents in this therapeutic class remain unmanaged); Systemic Juvenile Idiopathic Arthritis (sJIA) added to Targeted Immune Modulators class
	-- Criteria deleted: Hepatitis C requirements for HCV genotype/subtype testing, HCV RNA test
	   post-Hepatitis C treatment, pregnancy testing, hepatitis A and B vaccination, specific
	   therapeutic lab testing, and drug interaction screening
	-- New criteria were developed for the following medications: Ilaris (canakinumab); Infliximab
	   (Remicade and biosimilar products); Entyvio (vedolizumab); Stelara (usetekinumab) IV
	   injection; ACTEMRA (tocilizumab); Crysvita (burosumab); Brexafemme (ibrexafungerp);
	   Afinitor Disperz (everolimus); Cystadrops (cysteamine hydrochloride) and Aemcolo (rifamycin)
	-- Criteria were updated for the following medications: Revatio (sildenafil) oral suspension,
	   Stelara (ustekinumab) syringe for subcutaneous use, Spiriva Respimat (tiotropium) 2.5 mcg,
	   Uceris (budesonide ER) tablet; Otrexup, Rasuvo and Xatmep (methotrexate)
	
	February 8, 2022 Summary:
	-- New therapeutic classes added to the PDL: None
	-- Criteria deleted: None

Question	Response
	-- New criteria were developed for the following medications: Eysuvis and Inveltys (loteprednol etabonate); Livtencity (maribavir); Nexviazyme-ngpt (avalglucosidase alpha); Voxzogo (vosoritide) and Saphnelo (anifrolumab) -- Criteria were updated for the following medications: Nucynta (tapentadol); Xolair (omalizumab); TYRVAYA (varenicline); calcitonin gene-related peptide inhibitors (CGRPIs); oral triptans and multiple sclerosis agents May 10, 2022 Summary: - New therapeutic classes added to the PDL: Other Agents (including podofilox and imiquimod) added to the Topical Immunomodulators class - Criteria deleted: Bevyxxa (betrixaban) - New criteria were developed for the following medications: Opzelura (ruxolitinib); Veregen (sinecatechins); Zyclara (imiquimod); compounded products; Xarelto (rivaroxaban) oral Suspension; Besremi (ropeginterferon alfa-2b); Vyvgart (efgartigimod alfa); Leqvio (inclisiran); Adbry (tralokinumab-ldrm); Isturisa (osilodrostat); Recorlev (levoketoconazole) and Dojolvi (triheptanoin) - Criteria were updated for the following medications: Entresto (sacubitril/valsartan) and Brilinta (ticagrelor) August 9, 2022 Summary: - New therapeutic classes added to the PDL: None - Criteria deleted: None - New criteria were developed for the following medications: Baqsimi (glucagon); Zegalogue (dasiglucagon); Pyrukynd (mitapivat); Vijoice (alpelisib); Camzyos (mavacamten); Tepezza (teprotumumab); Ultomiris (ravulizumab); Nplate (romiplostim); Vyepti (eptinezumab); Lumizyme (alglucosidase alfa); Lemtrada (alemtuzumab); Eylea (aflibercept) - Criteria were updated for the following medications: Afrezza (human insulin); Steglatro (ertugliflozin); Benlysta (belimumab); Nexviazyme (avalglucosidase); Ocrevus

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Question	Response
	(ocrelizumab); Tysabri (natalizumab)
	Description of policies that establish whether and how results of ProDUR screening are used to adjust RetroDUR screens:
	ProDUR criteria can influence RDUR activity when there are utilization trends for a specific drug product or within a specific therapeutic class. This drug use activity may lead to further investigation of the impact of ProDUR changes on prescribing patterns (such as for opioids, benzodiazepines, or psychotropic medications in pediatric/adolescent members).
	Description of policies that establish whether and how results of RetroDUR screening are used to adjust ProDUR screens.:
	The DUR Board reviews trends in the RDUR reports on a quarterly basis, including the number of members with opioid claims resulting in a cumulative MME > 200. This process has, in some cases, led to further analyses being conducted by the CO-DUR team, with subsequent recommendations provided to the Colorado Department of Health Care Policy and Financing (HCPF).
	Description of DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.):
	The DUR Board reviews metrics associated with RetroDUR educational interventions (member-specific educational letters mailed to providers) during each quarterly meeting. Two educational DUR newsletters were published online during FFY 2022 (December 2021 and June 2022). The DUR Board is not directly involved in the development of these newsletters, although individual Board members are often included in biographical Spotlight articles. Newsletters are also directly distributed to Board members and other key DUR stakeholders by email. A library of recent Colorado DUR Newsletters is available at https://hcpf.colorado.gov/drug-utilization-review-board.
	Description of policies adopted to determine mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring):
	Interventional letters that contain patient-specific

Question	Response
	information are sent to prescribers on a quarterly basis. There is no specific policy to determine the areas of focus for these interventions, although clinical topics are often identified through utilization patterns, changes in FDA product labeling, and clinical module analyses prepared by the University of Colorado Skaggs School of Pharmacy (see Colorado Summary 5: Innovative practices). Recent educational letters mailed to providers have included high risk psychotropic prescribing in members less than 18 years of age, cumulative MMEs greater than 150 with no claim for naloxone within the past 12 months, concomitant claims for opioid/skeletal muscle relaxant/benzodiazepine combinations, and evidence of overlapping claims for two or more benzodiazepines.

Section V - Physician Administered Drugs (PAD)

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

Question	Response
1. ProDUR?	Yes
If "No," does your State have a plan to include this information in your DUR criteria in the future?	N/A
2. RetroDUR?	Yes
If "No," does your State 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 3 – Generic Drug Substitution Policies Generic Drug Substitution Policies should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, preferred drug list (PDL) policies, educational initiatives, technology or promotional factors, or other State-specific factors that affects your generic utilization rate.	Policy for mandated use of generic product formulations (generic mandate policy): Brand name drug products that have generic equivalent product formulations (multi-source innovator products) require a prior authorization. Exceptions to this include cases where the brand name drug has been exempted from the generic mandate policy based on use for the following circumstances: - The Department designates favored coverage of the brand drug product based on net cost for the brand product being lower than that of the generic equivalent (designated brand favored products are listed on the 'Brand Favored Product List' for reference on the Department's Pharmacy Resources webpage). - The physician is of the opinion that a transition to the generic equivalent of a brand drug product would be unacceptably disruptive to the patient's stabilized drug regimen. - The patient is started on a generic drug but is unable to continue treatment on the generic drug as determined by the patient's physician. - The medication is being prescribed for the treatment of any of the following disease states (which are exempt from the generic mandate policy): Biologically based mental illness (as defined in 10-16-104 (5.5) C.R.S.), cancer, epilepsy, or HIV/AIDS. Other drug management strategies to encourage use of generic product formulations: Our program has implemented a Preferred Drug List (PDL) which, by incorporating available evidence-based research and public testimony, provides clinical guidance for necessary drug therapies. During implementation of these recommendations, the program provides advantage to products that are most cost effective. Using these methods, we have been able to enhance generic utilization without sacrificing quality of care by preferring generic drug options when clinically appropriate.

Question	Response
2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your State have a more restrictive requirement?	Yes
If "Yes," check all that apply.	Other
If "Other," please explain.	Prescriptions for multi-source innovator medications may require prior authorization with prescriber attestation that (1) transition to the generic equivalent of the brand name product would be unacceptably disruptive to the member's stabilized drug regimen, or (2) that the member is unable to continue treatment with the generic, as determined by the prescriber, following initial treatment.

Generic Drug Utilization Data

Computation Instructions KEY

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

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

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

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

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

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

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

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I.

Table 2 – Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	885,433.00	6,480,450.00	459,047.00
Total Reimbursement Amount Less Co-Pay	$1,045,267,716.98	$123,783,996.07	$173,504,634.83

Question	Response
3. Indicate the generic utilization percentage for all covered outpatient drugs (COD) paid during this reporting period, using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Number of Generic Claims	6,480,450
Total Number of Claims	7,824,930
Generic Utilization Percentage	83%
4. How many innovator drugs are the preferred product instead of their multi-source counterpart based on net pricing (i.e. brand name drug is preferred over equivalent generic product on the PDL)?	61
5. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Generic Dollars	$123,783,996
Total Dollars	$1,342,556,348
Generic Expenditure Percentage	9%
6. Does your State have any policies related to Biosimilars? Please explain.	Colorado law allows pharmacists to substitute a prescribed biologic for a biosimilar that has been determined by the FDA to be interchangeable, provided that the prescriber has not indicated Dispense as Written on the order. Pharmacists must notify both the prescriber and the prescription purchaser of the substituted product. Reference biological products and biosimilars are managed on the PDL and Appendix P for the pharmacy benefit.

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

Cost Avoidance	Cost in Dollars
ProDUR Total Estimated Avoided Costs	$883,521,832.05
RetroDUR Total Estimated Avoided Costs	$0.00
Other Cost Avoidance	$0.00
Grand Total Estimated Avoided Costs	$883,521,832.05

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 5, then multiplying this value by 100.	65.81%
4. Does your Medicaid program provide coverage of over-the-counter medications when prescribed by an authorized prescriber?	Yes
If "No," please explain why not.	N/A

Question	Response
5. Summary 4 – Cost Savings/Cost Avoidance Methodology Cost Savings/Cost Avoidance Methodology Summary should include program evaluations/cost savings estimates prepared by the State or contractor.	Paid Claims Cost Avoidance is calculated by taking the paid dollar amount of claims with a ProDUR message that paid but were subsequently reversed and subtracting the paid amount the claims resubmitted within 72 hours. (Claim Amount minus Reversal Amount + Resubmit Amount) Denied Claims Cost Avoidance is calculated by taking the submitted dollar value of the claims that were initially denied and had a ProDUR message and subtracting any of those claims that were then resubmitted within the same calendar month and then paid. (Claim Amount minus Resubmit Amount) ProDUR Total Estimated Avoided Costs = Denied Claims Cost Avoidance + Paid Claims Cost Avoidance

Section VIII - Fraud, Waste and Abuse Detection

A. Lock-In or Patient Review and Restriction Programs

Question	Response
1. Does your State 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 (multiple responses allowed)?	Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
If "Other," please explain.	N/A
If "No," please explain why not.	N/A
2. Does your State have a lock-in program for beneficiaries with potential misuse or abuse of controlled substances? If "Yes," please continue.	Yes
a. What criteria does your State use to identify candidates for lock-in (multiple responses allowed)?	Number of controlled substances (CS), Different prescribers of CS, Multiple pharmacies, Multiple emergency room (ER) visits
If "Other," please explain.	N/A
b. Does your State have the capability to restrict the beneficiary to:	
i. Prescriber only	Yes
ii. Pharmacy only	Yes
iii. Prescriber and Pharmacy	Yes
c. What is the usual lock-in time period?	12 months
If "Other," please explain.	N/A
d. On average, what percentage of the FFS population is in lock-in status annually?	1.0000%
e. Please provide an estimate of the savings attributed to the lock-in program for the fiscal year under review.	$0.00
3. Does your State have a documented process in place that identifies possible FWA of controlled drugs by prescribers?	Yes
If "Yes," what actions does this process initiate (multiple responses allowed)?	Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
If "Other," please explain.	N/A

Question	Response
If "No," please explain why not.	N/A
4. Does your State have a documented process in place that identifies potential FWA of controlled drugs by pharmacy providers?	Yes
If "Yes," what actions does this process initiate (multiple responses allowed)?	Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
If "Other," please explain.	N/A
If "No," please explain why not.	N/A
5. Does your State have a documented process in place that identifies and/or prevents potential FWA of non-controlled drugs by beneficiaries, prescribers, and pharmacy providers?	Yes
If "Yes," please explain your program for FWA of non-controlled substances.	Retrospective DUR analyses and prior authorization are used to identify these issues. Beneficiaries are referred to the Program Integrity Unit that works with individual counties.
If "No," please explain why not.	N/A

B. Prescription Drug Monitoring Program (PDMP)

Question	Response
1. Does your Medicaid program have the ability to query the State's PDMP database?	No
If "No," please explain.	The State is prohibited by law from accessing the PDMP.
If "Yes," please continue. a. How does your State access the PDMP database (multiple responses allowed)?	N/A
If "Receive PDMP data" please indicate how often (multiple responses allowed).	N/A
If "Other," please explain.	N/A
If "Direct access to the database," please specify (multiple responses allowed).	N/A
a. Please explain how the State applies this information to control FWA of controlled substances.	N/A

Question	Response
b. Does your State also have access to contiguous States' PDMP information?	N/A
c. Does your State also have PDMP data integrated into your point of sale (POS) edits?	N/A
2. Have you communicated to prescribers who are covered providers that as of October 1, 2021, they are required to check the PDMP before prescribing controlled substances to beneficiaries who are covered individuals?	Yes
If "Not applicable," or "No," please explain.	N/A
If "Yes," please check all that apply.	Public notice, Provider manual
If "Other," please explain.	N/A
If "Yes," please continue. a. Has the State specified protocols for prescribers checking the PDMP?	Yes
If "Yes," please explain.	Colorado law requires that prescribers query the PDMP prior to prescribing any opioid or benzodiazepine prescription unless the patient receiving the prescription meets specific exceptions to this requirement as defined in statute (Colorado Revised Statutes Title 12 Professions and Occupations). Department policy states that Colorado Medicaid providers permitted to prescribe controlled substances must query the Colorado Drug Monitoring Program (PDMP) before prescribing controlled substances to Medicaid members, in accordance with Section 5042 of the "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and the Communities Act (SUPPORT Act)"; and the requirement to check the PDMP does not apply when a member: Is receiving the controlled substance in a hospital, skilled nursing facility, residential facility, or correctional facility Has been diagnosed with cancer and is experiencing cancer-related pain Is undergoing palliative care or hospice care Is experiencing post-surgical pain that, because of the nature of the procedure, is expected to last more than 14 days Is receiving treatment during a natural disaster or during an incident where mass casualties have taken place

Question	Response
	Has received only a single dose to relieve pain for a single test or procedure
b. Do providers have protocols for responses to information from the PDMP that is contradictory to information that the practitioner expects to receive, based on information from the client (example: when a provider prescribing pain management medication finds medications for opioid use disorder (OUD) during a PDMP check, when client denies opioid use disorder)?	No
c. If a provider is not able to conduct PDMP check, does your State require the prescriber to document a good faith effort, including the reasons why the provider was not able to conduct the check?	Yes
If "No," please explain why not.	N/A
If "Yes," does your State require the provider to submit, upon request, documentation to the State?	Yes
If "No," please explain.	N/A
3. In the State's PDMP system, which of the following beneficiary information is available to prescribers as close to real-time as possible (multiple responses allowed)?	The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period, The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills, Other, PDMP drug history
If "Other," please explain.	Beneficiary's current calculated daily or average MME Description of payment method used for controlled substance prescriptions dispensed to the beneficiary
a. Are there barriers that hinder the Medicaid agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb FWA?	Yes

Question	Response
If "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).	The State is prohibited by legislation from accessing the PDMP. The requirement for prescribers to check the PDMP prior to prescribing controlled substances to Medicaid members in accordance with Section 5042 of the 'SUPPORT for Patients and Communities Act' is reflected in posted Department policy.
4. Have any changes to your State's PDMP during this reporting period improved or detracted from the Medicaid program's ability to access PDMP data?	Yes
If "Yes," please explain.	The Department has made progress with exploring strategies for obtaining the PDMP data needed for the mandatory reporting submitted to CMS with the FFY 2023 DUR survey.
5. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?	No
If "Yes," please summarize the breach, the number of individuals impacted, a description of the steps the State has taken to address each such breach, and if law enforcement or the affected individuals were notified of the breach.	N/A

C. Opioids

Question	Response
1. Does your State currently have a POS edit in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients?	Yes, for all opioids
If "No," please explain why not.	N/A
If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue. If the answer to question 1 is "No," please skip to 1b. a. What is the maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?	7

Question	Response
b. Does your State have POS edits in place to limit days' supply of subsequent opioid prescriptions? If "yes," please indicate your days' supply limit.	Other
If "Other", please specify.	7
If "No," please explain.	N/A
2. Does your State have POS edits in place to limit the quantity dispensed of opioids?	Yes
If "No," please explain why not.	N/A
If "Yes," please continue. a. Does your State have POS edits in place to limit the quantity dispensed of short-acting (SA) opioids?	Other
If "Yes," please specify limit as # of units.	N/A
If "No," or "Other," please explain.	Opioid naive members are limited to a quantity of 8 pills per day. For members that are not opioid naive, short-acting opioids are limited to a quantity of 120 pills per 30 days, with exception of tapentadol IR, which is limited to 180 tablets per 30 days.
b. Does your State currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?	Other
If "Yes," please specify limit as # of units.	N/A
If "No," or "Other," please explain.	Long-acting opioids are subject to quantity limits listed for specific products on the preferred drug list.
3. Does your State have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?	Yes
If "Yes," check all that apply.	Other, Deny claim and require PA, Intervention letters, Requirement that prescriber has an opioid treatment plan for patients, MME daily dose program, Step therapy or clinical criteria

Question	Response
If "Other," please specify.	Prescriptions are limited to one long-acting opioid (including different strengths) and one short-acting opioid (including different strengths) for opioid prior authorization approvals. Opioid-naive members are limited to short-acting opioids only. Prescriber opioid treatment plans are documented as part of provider-to-provider telephone consultations that are required for certain opioid prior authorizations.
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
4. Does your State have POS edits to monitor duplicate therapy of opioid prescriptions? This excludes regimens that include a single extended-release product and a breakthrough short acting agent?	Yes
If "No," please explain why not.	N/A
5. Does your State have POS edits to monitor early refills of opioid prescriptions dispensed?	Yes, both POS edits and automated retrospective claims review process
If "No," please explain why not.	N/A
6. Does your State have comprehensive automated retrospective claim reviews to monitor opioid prescriptions exceeding these State limitations (early refills, duplicate fills, quantity limits and days' supply)?	Yes
If "Yes," please explain in detail scope, nature, and frequency of these retrospective reviews.	Retrospective claims review of member opioid utilization is conducted as part of pharmacy call center procedures for processing automated prior authorizations requiring provider-to-provider telephone consultation with the State's contracted pain management physician for cases where member opioid claims exceed a cumulative MME of 200, the fourth fill of an opioid occurs for a previously opioid-naive member, or the fourth fill occurs for an opioid prescribed by a dental provider. Retrospective DUR analysis is also conducted on an ongoing basis for monitoring of overall opioid utilization and MME among beneficiaries.
If "No," please explain why not.	N/A

Question	Response
7. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and benzodiazepines being used concurrently?	Yes, both POS edits and automated retrospective claim reviews
If "Yes," please explain above response and detail the scope and nature of these reviews and edits. Additionally, please explain any potential titration processes utilized for those patients chronically on benzodiazepines and how the State justifies pain medications, i.e., Oxycodone/APAP, for breakthrough pain without jeopardizing patient care (i.e., quantity limits/practitioner education titration programs).	ProDUR alert system edits are in place when concomitant opioid and benzodiazepine claims are submitted. Automated retrospective review of claims history identifies long-term use of either an opioid or benzodiazepine medication, and subsequent claims submitted for the respective concomitant medication will then deny for PA required. Retrospective claims review of member concomitant long-term use of a benzodiazepine with a prescribed opioid is evaluated as part of provider-to-provider telephone consultation with the State's contracted pain management physician, and titration processes may be evaluated as part of the consult based on the individualized treatment plan and with consideration for a specific member's needs. Retrospective DUR is also conducted and letters are sent to providers regarding members' concomitant use of these medications.
If "No," please explain why not.	N/A
8. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and sedatives being used concurrently?	Yes, automated retrospective claim reviews
If "No," please explain why not.	N/A
9. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and antipsychotics being used concurrently?	Yes, POS edits
If "No," please explain why not.	N/A
10. Does your State have POS safety edits or perform automated retrospective claims reviews and/or provider education regarding beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?	Yes
If "No," please explain why not.	N/A
If "Yes," check all that apply.	POS edits

Question	Response
If "Automated retrospective claim reviews" and/or "Yes, provider education," please indicate how often.	N/A
If "Other," please specify.	N/A
If "No," does your State plan on implementing POS edits, automated retrospective claim reviews and/or provider education regarding beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?	N/A
If "Yes," when does your State plan on implementing?	N/A
If "No," please explain why not.	N/A
11. Does your State Medicaid program develop and provide prescribers with pain management or opioid prescribing guidelines?	Yes
If "Yes," please check all that apply.	Other guidelines., Your state Medicaid program refers prescribers to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain.
If applicable, please identify the "other" guidelines.	N/A
If "No," please explain why no guidelines are offered.	N/A
12. Does your State have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e., presence of an abuse deterrent opioid with preferred status on your preferred drug list)?	Yes
If "Yes," please explain.	Availability and access for abuse deterrent opioid products managed on the Preferred Drug List is evaluated at least annually through the State's Pharmacy and Therapeutics (P&T) Committee and DUR Board review processes with consideration for safety, efficacy, and utilization of abuse deterrent product formulations.
If "No," please explain.	N/A

Question	Response
13. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency?	Yes
If "Yes," please explain.	Retrospective DUR analyses were conducted in October 2020 and January 2021 (and also subsequent to the FFY22 reporting period) to evaluate opioid utilization trends among beneficiaries during the course of the COVID-19 public health emergency. An ad hoc claims review analysis conducted in October 2020 for the time period 10/1/2019 to 9/30/2020 (6 months pre- and post-onset of the COVID-19 pandemic) showed that prescribed utilization of both shorting-acting and long-acting opioids remained stable in the Colorado Medicaid population.

D. 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?	200 MME mg per day
If "Less than 50 MME," please specify the amount in mg per day.	N/A mg per day
If "Greater than 200 MME," please specify the amount in mg per day.	N/A mg per day
If "Other," please specify the amount in mg per day.	N/A mg per day
b. Please explain nature and scope of dose limit (i.e., Who does the edit apply to?, Does the limit apply to all opioids?, Are you in the process of tapering patients to achieve this limit?).	Prior authorization involving a prescriber-to-prescriber consult is required for beneficiary claims for long-acting or short-acting opioids that exceed the cumulative MME limit. An opioid prescribing plan and recommendations for tapering are documented as part of this consult, and approval may be placed to allow for continuation or tapering. Exceptions apply when opioids are prescribed to treat sickle cell anemia, pain associated with cancer, or in association with hospice or end of life care.
If "No," please explain why not.	N/A

Question	Response
2. Does your State have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?	Yes
If "Yes," does your State require PA if the MME limit is exceeded.	Yes
If "No," please explain why not.	N/A
3. Does your State have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed?	Yes
If "No," please explain why not.	N/A
4. Do you provide information to your prescribers on how to calculate the MME daily dosage or do you provide a calculator developed elsewhere? If "Yes," please continue.	Yes
a. Please name the developer of the calculator.	Other
If "Other," please specify.	Washington State Agency Medical Directors' Group (AMDG)
b. How is the information disseminated (multiple responses allowed)?	Website
If "Other," please explain.	N/A

E. Opioid Use Disorder (OUD) Treatment

Question	Response
1. Does your State have utilization controls (i.e., preferred drug list (PDL), prior authorization (PA), quantity limit (QL)) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?	Yes
If "Yes," please explain.	During the reporting period, prior authorization requirements were removed for Suboxone (buprenorphine/naloxone) sublingual film. All other oral buprenorphine-containing medications used to treat OUD require prior authorization verifying appropriate use. A quantity limit of 24 mg buprenorphine per day is applied to all oral buprenorphine-containing medications used to treat OUD. Pharmacy benefit place of service prior authorization requirements were also removed for Vivitrol (naltrexone ER) injection during the reporting period . Other injectable formulations of medications used to treat OUD require prior authorization for cases where eligible for billing under the pharmacy benefit.
If "No," please explain.	During the reporting period, prior authorization requirements were removed for Suboxone (buprenorphine/naloxone) sublingual film. All other oral buprenorphine-containing medications used to treat OUD require prior authorization verifying appropriate use. A quantity limit of 24 mg buprenorphine per day is applied to all oral buprenorphine-containing medications used to treat OUD. Pharmacy benefit place of service prior authorization requirements were also removed for Vivitrol (naltrexone ER) injection during the reporting period . Other injectable formulations of medications used to treat OUD require prior authorization for cases where eligible for billing under the pharmacy benefit.
2. Does your Medicaid program 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

Question	Response
3. What are your limitations on the allowable length of this treatment?	No limit
If "Other," please explain.	N/A
4. Does your State 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
5. Does your State have at least one buprenorphine/naloxone combination product available without PA?	Yes
6. Does your State currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?	Yes
If "No," please explain why not.	N/A
If "Yes," can the POS pharmacist override the edit?	Yes
7. Is there at least one formulation of naltrexone for OUD available without PA?	Yes
8. Does your State have at least one naloxone opioid overdose product available without PA?	Yes
9. Does your State monitor and manage appropriate use of naloxone to persons at risk of overdose?	Yes
If "No," please explain why not.	N/A

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

F. Outpatient Treatment Programs (OTP)

Question	Response
1. Does your State cover OTPs that provide Behavioral Health (BH) and MAT services?	Yes
If "No," please explain why not.	N/A
If "Yes," is a referral needed for OUD treatment through OTPs?	No
Please explain.	Behavioral health services including SUD treatment are available to all members without the need for a referral or copay.
2. Does your State Medicaid program cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?	Yes
If "No," please explain.	N/A
3. Does your State Medicaid program cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?	Yes
If "No," please explain.	N/A
4. Does your State Medicaid program cover Methadone for a substance use disorder (i.e., OTPs, Methadone Clinics)?	Yes
If "No," please explain why not.	N/A

G. Psychotropic Medication For Children

Antipsychotics

Question	Response
1. Does your State currently have restrictions in place to limit the quantity of antipsychotic drugs?	Yes
Please explain restrictions or N/A.	Quantity and age limits are in place.
2. Does your State have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children? If "Yes," please continue.	Yes
a. Does your State either manage or monitor:	All children
If "Other," please explain.	N/A
b. Does your State have edits in place to monitor (multiple responses allowed):	Child's age, Dosage, Indication
Specify child's age limit in years.	5
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antipsychotic monitoring program(s).	Edits are in place to identify doses exceeding maximum and off-label uses based on atypical antipsychotic indications for use and patient age and require prior authorization potentially involving a child/adolescent psychiatrist consult. Retrospective DUR is conducted and letters are sent to providers regarding pediatric members' use of multiple psychotropic medications (including antipsychotic medications). Retrospective DUR module analyses are conducted to evaluate pediatric psychotropic medication prescribing and utilization.
If "No," does your State plan on implementing an antipsychotic monitoring program in the future.	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children.	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. Does your State currently have restrictions in place to limit the quantity of stimulant drugs?	Yes
4. Does your State have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children? If "Yes," please continue.	Yes
a. Does your State either manage or monitor:	All children
If "Other," please explain.	N/A
b. Does your State have edits in place to monitor (multiple responses allowed):	Dosage, Indication, Other
Specify child's age limit in years.	N/A
If "Other," please explain.	Age limit edits are in place and applied to individual stimulant medications based on FDA labeling or clinical compendia supported use.
c. Please briefly explain the specifics of your documented stimulant monitoring program(s).	Edits are in place for maximum dose, off-label use, and patient age. Prior authorization and expanded clinical review by a pharmacist may be required when any of these limitations are exceeded. Retrospective DUR is conducted and letters are sent to providers regarding pediatric members' use of multiple stimulant medications or use of multiple psychotropic medications (including stimulants). Retrospective DUR module analyses are conducted to evaluate pediatric psychotropic medication prescribing and utilization.
If "No," does your State plan on implementing a stimulant monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.	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

Antidepressants

Question	Response
5. Does your State have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children? If "Yes," please continue.	Yes
a. Does your State either manage or monitor:	All children
If "Other," please explain.	N/A
b. Does your State have edits in place to monitor (multiple responses allowed):	Polypharmacy
Specify child's age limit in years.	N/A
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antidepressant monitoring program(s).	Interventional letters that contain patient-specific information identifying use of multiple psychotropic medications (including antidepressants) in children/adolescents are prepared and mailed to prescribers periodically. Retrospective DUR module analyses are conducted to evaluate pediatric psychotropic medication prescribing and utilization.
If "No," does your State plan on implementing an antidepressant monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antidepressant drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antidepressant drugs in children.	N/A

Mood Stabilizers

Question	Response
6. Does your State have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children? If "Yes," please continue.	Yes
a. Does your State either manage or monitor:	All children
If "Other," please explain.	N/A
b. Does your State have edits in place to monitor (multiple responses allowed):	Polypharmacy
Specify child's age limit in years.	N/A
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented mood stabilizer monitoring program(s).	Interventional letters that contain patient-specific information identifying use of multiple psychotropic medications (including mood stabilizers) in children/adolescents are prepared and mailed to prescribers periodically. Retrospective DUR module analyses are conducted to evaluate pediatric psychotropic medication prescribing and utilization.
If "No," does your State plan on implementing a mood stabilizer monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of mood stabilizing drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of mood stabilizing drugs in children.	N/A

Antianxiety/Sedatives

Question	Response
7. Does your State have a documented program in place to either manage or monitor the appropriate use of antianxiety/sedative drugs in children? If "Yes," please continue.	Yes
a. Does your State either manage or monitor:	All children
If "Other," please explain.	N/A
b. Does your State have edits in place to monitor (multiple responses allowed):	Child's age
Specify child's age limit in years.	18
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).	Edits are in place for maximum dose, duplicate sedative hypnotic use, and patient age. Prior authorization and expanded clinical review by a pharmacist may be required when any of these limitations are exceeded. Retrospective DUR is conducted and letters are periodically sent to providers regarding pediatric members' use of multiple psychotropic medications (including antianxiety/sedative medications). Retrospective DUR module analyses are conducted to evaluate pediatric psychotropic medication prescribing and utilization.
If "No," does your State plan on implementing an antianxiety/sedative monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.	N/A

Section IX - Innovative Practices

Question	Response
1. Does your State participate in any demonstrations or have any waivers to allow importation of certain drugs from Canada or other countries that are versions of FDA-approved drugs for dispensing to Medicaid beneficiaries?	Yes
If "Yes," please explain.	The Colorado General Assembly passed legislation in 2019 authorizing the importation of certain drugs from eligible Canadian suppliers.
2. Summary 5 – Innovative Practices Innovative Practices Summary should discuss development of innovative practices during the past year (i.e., Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing). Please describe in detailed narrative below any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs (i.e., disease management, academic detailing, automated PA, continuing education programs).	VALUE BASED CONTRACTING The Department entered into two value based contracts (VBCs) during the reporting period. Activity continues to expand in this space and additional VBC contracts will be reported in future annual survey reports. PROVIDER EDUCATIONAL INTERVENTION FOR NALOXONE AND OPIOID USE SAFETY As part of a don't forget the naloxone campaign, an educational letter for providers was specifically developed and implemented in June 2021 and has continued through FFY 2022. This interventional letter, based in part on the July 2020 FDA Drug Safety Communication, alerts prescribers to patients are taking opioids at a cumulative dose of MME greater than 150 and also do not have a naloxone claim administratively identified in the previous 12 months. Members may obtain naloxone from other sources; however, the new letter prompted conversations between prescribers and patients to promote opioid safety at home. HEALTH FIRST COLORADO PRESCRIBER TOOL The Health First Colorado Prescriber Tool is a platform accessible to prescribers through most electronic health record (EHR) systems. The goals of the Prescriber Tool project are to (1) help improve health outcomes, (2) reduce administrative burdens for prescribers, and (3) better manage prescription drug costs .The Prescriber Tool provides patient-specific information to prescribers at the point of care. The opioid risk mitigation module was originally implemented January 1, 2021 in collaboration with OpiSafe. This module provides easy access to PDMP data, tools for evidence-based treatment and overdose

Question	Response
	prevention, and identification of Opioid Use Disorder (OUD). Each prescriber must have an individual license to access the opioid risk module. Each license will provide prescribers with access to information for all their patients, including those not covered by Health First Colorado. The affordability module implemented on June 1, 2021 allows for electronic submission of prescriptions and prior authorization requests, plus real time patient-specific pharmacy benefit information. HEALTH FIRST COLORADO Rx REVIEW MTM PROGRAM Colorado's Rx Review MTM program identifies cohorts of Medicaid members most likely to benefit from a detailed medication review. Cohorts are identified through the diagnosis of a specific chronic disease state (such as asthma, heart failure, migraine or hypertension) plus a polypharmacy component based on quarterly prescription medication claims data. Pharmacists and pharmacy interns conduct telephone medication reviews with individual members to identify therapeutic duplications, drug interactions, untreated or undertreated medical conditions, adverse drug effects, COVID-19 vaccination status, medication non-adherence, and therapeutic drug monitoring requirements. Detailed summary letters are mailed to both members and their providers. UNIVERSITY OF COLORADO SKAGGS SCHOOL OF PHARMACY DUR INTERN PROGRAM Faculty at the University of Colorado Skaggs School of Pharmacy oversee a unique DUR Intern Program to support the contractual agreement between the Department and the university. DUR Interns assist with drug information research through winter and summer assigned projects, prepare and present FDA New Approval and Safety Report at quarterly DUR Board meetings, verbally present selected proposed DUR criteria to the Board, prepare RetroDUR provider education letters for mailing each quarter, contribute articles to DUR Newsletters, and manage the technical aspects of virtual DUR Board meetings. PEER-REVIEWED PUBLICATIONS The Department collaborates with the DUR team at the University Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences to occasionally publish peer-

Question	Response
	reviewed papers. An in-depth evaluation of the Health First Colorado Pain Management Teleconsultation Service was undertaken during FFY 2022 and was subsequently published. More details about this analysis and other peer-reviewed publications will be included in next year's report. UNIVERSITY OF COLORADO QUARTERLY CLINICAL RESEARCH MODULES As part of the Department's contract with the CU Skaggs School of Pharmacy and Pharmaceutical Sciences, quarterly clinical research modules are produced each quarter to provide more granular evaluations of medication related issues and drug use policies that are pertinent to Health First Colorado members. The Department uses these data to make policy changes and improve medication safety and quality of care for our members. The four quarterly research module evaluations conducted during FFY 2022 are summarized below. CLINICAL MODULE 1: Utilization of Antiretroviral Therapy for treatment of HIV Among Health First Colorado Members (Delivered 12/31/2021) Objective 1: Identify and describe members with HIV (Type 1 and Type 2) who are receiving ART Objective 2: Describe ART utilization and adherence among members with HIV who are receiving ART Objective 3: Describe initiation of HIV regimens for members newly diagnosed with HIV CLINICAL MODULE 2: Consult Service Clinical Outcomes Investigation: An Updated Assessment of Pain Management Specialty (Delivered 3/31/22) Objective 1: Describe members participating in the Opioid Consult Service Objective 2: Estimate the effect of the Opioid Consult Service on opioid use CLINICAL MODULE 3: Targeted Immune Modulators: Analysis of Select Biological Products (Delivered 6/30/2022) Objective 1: Identify and describe members receiving select biologic agents Objective 2: Describe history of FDA-indicated diagnoses and utilization of select biologic agents Objective 3: Describe the utilization and cost of select

Question	Response
	biologic agents CLINICAL MODULE 4: Psychotropic Medication Use among Pediatric and Adolescent Members of Health First Colorado (Delivered 9/30/2022) (psychotropic medications analyzed included stimulants, antipsychotics, anti-anxiety agents, mood stabilizers, and antidepressants) Objective 1: Identify and describe pediatric and adolescent members receiving psychotropic medications Objective 2: Describe psychotropic medication use by therapeutic class Objective 3: Describe psychotropic medication use and enrollment in Colorado's child welfare system

Section X - Managed Care Organizations (MCOs)

Question	Response
1. How many MCOs are enrolled in your State Medicaid program? If "Zero" or "None", please skip the rest of this section.	2
2. Is your pharmacy program included in the capitation rate (carved in)?	Partial
If "Partial, "please check what categories of medications are carved out and handled by your FFS program (multiple responses allowed):	Other
If "Other," please specify the drug categories.	Certain outpatient hospital specialty drugs are carved out from Enhanced Ambulatory Patient Group (EAPG) payment. These drugs include Brineura, Carvykti, Tecartus, Spinraza, Kymriah, Yescarta, Danyelza, and Zolgensma.
3. Contract updates between State and MCOs addressing DUR provisions in Section 1004 Support for Patients and Communities Act are required based on 1902(oo). If covered outpatient drugs are included in an MCO's covered benefit package, has the State updated their MCOs' contracts for compliance with Section 1004 of the SUPPORT for Patients and Communities Act?	Yes, contracts are updated to address each provision
If "Yes," please specify effective date.	07/01/2021
If "No, contracts are not updated," please explain why not.	N/A
a. Is the State complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions?	Yes, state is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions
If "Yes," State is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions. Please explain monitoring activities.	The State DUR Contact and other members of the State's Pharmacy Office team work directly with designated MCO DUR program pharmacist contacts (for each of the State's two MCOs) to coordinate DUR program activities and verify compliance with these provisions.
If "No," please explain why not.	N/A

Question	Response
4. Does the State set requirements for the MCO's pharmacy benefit (i.e., same preferred drug list, same ProDUR/RetroDUR)?	Yes
a. If "Yes," check all that apply.	Formulary Reviews
b. Please briefly explain your policy.	The State's policy is that MCO medication coverage and utilization limitations cannot be more stringent than current limitations in place for FFS. If a drug is carved out, then MCOs must follow the State's FFS PDL and associated prior authorization criteria.
If "No," does your State plan to set standards in the future?	N/A
If "No," please explain.	N/A
5. Is the RetroDUR program operated by the State or by the MCOs or does your State use a combination of State interventions as well as individual MCO interventions?	State uses a combination of state interventions as well as individual MCO interventions
6. Indicate how the State oversees the FFS and MCO RetroDUR programs? Please explain oversight process.	The State's two MCOs each have designated DUR program pharmacist contacts that collaborate with the State DUR Contact and other members of the State's Pharmacy Office team regarding MCO RetroDUR program activities. MCO DUR contractual obligations are also managed through coordinated efforts involving the MCO contract management team within the State's Health Programs Office.
7. How does the State ensure MCO compliance with DUR requirements described in Section 1927(g) of the Act and 42 C.F.R. § 456, subpart K?	Designated DUR program pharmacist contacts for the State's two MCOs collaborate with the State DUR Contact and other members of the State's Pharmacy Office team regarding DUR activities. MCO DUR contractual obligations are also managed through coordinated efforts involving the MCO contract management team within the State's Health Programs Office. Verification and monitoring of MCO compliance with DUR requirements is conducted by direct communication from the State to the MCO DUR program pharmacist contacts.
8. Did all of your managed care plans submit their DUR reports?	Yes
If "No," please explain why not.	N/A

Section XI - Executive Summary

Question	Response
1. Summary 6 – Executive Summary Executive Summary should provide a brief overview of your program. It should describe FFY 2021 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.	The Health First Colorado (Colorado Medicaid) DUR program is in its tenth year of collaboration with the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences (SSPPS). The DUR program continues to contract with a pain management physician specialist and a child and adolescent psychiatrist for teleconsultation services. In addition to the subcontracted specialists, there are two clinical faculty members, an administrative faculty member, a biostatistician/analyst, a pharmacy outcomes researcher, and a pharmacy outcomes PhD student involved in conducting quarterly DUR-related analyses and performing other DUR program activities. One clinical faculty member serves as a contracted clinical consultant and SSPPS liaison to the State, working directly with the State DUR Pharmacist and other members of the Department's Pharmacy Office team. During the time period of the reporting fiscal year, the Department observed a significant increase in electronic prior authorization (PA) request submissions when compared to traditional phone and fax requests. This increasing trend has been ongoing since implementation of the electronic prior authorization functionality in FFY21 as a component module of the Health First Colorado Prescriber Tool platform. The Department made changes to allow pharmacists enrolled as prescribers with Health First Colorado to prescribe opioid antagonists indicated for treating drug overdose in alignment with implementation of changes to Colorado Revised Statues C.R.S. 12-30-110 and C.R.S 12-280-123. In conjunction with the signing of Colorado SB21-009, the Department implemented changes to coverage and utilization management for medications provided in conjunction with family planning related services and made changes to allow $0 copay for these medications. The Department also removed place of service PA requirements for long-acting injectable antipsychotic medications filled through the pharmacy benefit, allowing pharmacy claims for these medications to pay with no PA required. Other noteworthy changes made to pharmacy benefit coverage during the reporting period included removal of PA requirements for brand Suboxone (buprenorphine/naloxone) sublingual films, removal of

Question	Response
	place of service PA requirements for Vivitrol (naltrexone ER), removal of PA requirements for medications used for initial treatment of hepatitis C. The Department also implemented new value based contractual agreements and expanded the number of physician-administered drugs managed with PA under the medical benefit.
	Colorado's DUR program sent out provider educational outreach letters encouraging naloxone prescribing for high-risk beneficiaries receiving opioids; identifying beneficiaries receiving multiple benzodiazepine medications or opioid, benzodiazepine, and muscle relaxant medications concomitantly; and identifying children and adolescents receiving multiple antipsychotic medications. The DUR team worked collaboratively with the contracted opioid prescriber consult pain management physician to implement a more comprehensive data tracking system for Health First Colorado members and providers who interact with pain management consultation service. Based on feedback received from other state DUR programs, Colorado's DUR team conducted a reporting analysis of lorazepam oral liquid formulation utilization to rule out misuse or abuse of this product within the Health First Colorado population. The SSPSS DUR program team produced pharmacy intern projects to summarize the details of REMS program additions in 2020 and 2021 and also conduct literature searches to evaluate efficacy and safety of the clinical use of stimulant medications (such as 'basal-bolus' dosing, use in combination with buprenorphine, and concomitant use of two chemically distinct stimulant medications). DUR Board meeting agendas have continued to be very full as additional drug classes were added to the State's FFS pharmacy PDL and new PA criteria were developed and reviewed by the Board for selected non-PDL medications and physician administered drugs covered under the pharmacy and/or medical benefit. New Preferred Drug List classes added during FFY 2022 included oral Human Immunodeficiency Virus (HIV) agents (though all medications in this class remain preferred with no coverage or PA limitations), systemic juvenile idiopathic arthritis (added to the 'Targeted Immune Modulators' drug class), and topical immunomodulators and related agents. The DUR Board continues to have high quality discussions leading to high

Question	Response
	quality recommendations made to the Department. DUR Board meetings continue to be held virtually, occurring at a quarterly frequency and lasting around 5 hours.