Connecticut
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?	995,878
2. On a monthly average, how many of your State's Medicaid beneficiaries are enrolled in managed care plan(s)?	0

Section II - Prospective DUR (ProDUR)

Question	Response
1. Indicate the type of your pharmacy point of service (POS) vendor.	Contractor
a. Vendor Name	Gainwell Technologies
b. Who processes the State's National Council for Prescription Drug Programs (NCPDP) transactions?	POS vendor is the fiscal agent (FA)
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)?	Yes
If "Yes" or "Varies by Alert Type," check all that apply.	Alerts can be overridden with standard professional codes, Alerts need prior authorization (PA) to be overridden
If "Other," please explain.	N/A
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)?	Monthly
If "Other," please explain.	N/A
b. If you receive reports, does your State follow up with those providers who routinely override with interventions?	No
If "Yes," by what method does your State follow up (multiple responses allowed)?	N/A
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:	93%
ii. Schedule II controlled drugs:	93%
iii. Schedule III through V controlled drugs:	93%
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?	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):	Overrides are only allowed by a pharmacist through a PA, Other
If "Other," please explain.	For non-CS for lost or stolen or vacation, either the pharmacist or prescriber can override with a PA. For CS for lost or stolen or vacation, only the prescriber can request a PA.
7. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?	No
If "Yes," please explain your edit.	N/A
If "No," does your State plan to implement this edit?	No

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)?	Yes
9. Does your system have a diagnosis edit that can be utilized when processing a prescription?	Yes
If "Yes," please explain.	The capability to require a diagnosis code on a claim for a specific drug is available. Failure to put the diagnosis code on the claim will result in a denied claim. Additional edits are in place to deny claims when specific diagnosis code(s) is/are configured to a specific drug. When these specific diagnosis codes are not found on the claim, the claim will deny.
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.	Direct involvement with Pharmacy and/or Medical Director, Pharmacist or technician reviews, Automatic PA based on diagnosis codes or systematic review, Trial and failure of first or second line therapies
If "Other," please explain.	N/A
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.	The pharmacist has the ability to perform a onetime override at POS.
If "No," please explain why not.	N/A
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)
semaglutide SUBCUT 0.25 OR .5 PEN INJCTR	ANTICONVULSANTS	PRODUR ALERT REQUIRES PA OVERRIDE	HUMIRA(CF) PEN	3.55%	PROAIR HFA	2.46%
albuterol sulfate INHALATION 90 MCG HFA AER AD	OPIOID ANALGESICS	CLAIM FAILED A PRODUR ALERT	BIKTARVY	2.40%	IBUPROFEN	1.87%
oxycodone HCl ORAL 5 MG TABLET	ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEP.AGONIST)	INFORMATIONAL PRODUR ALERT	TRULICITY	2.22%	GABAPENTIN	1.86%
blood sugar diagnostic MISCELL STRIP	PROTON-PUMP INHIBITORS	No Coverage for Billed NDC	SUBOXONE	2.00%	ATORVASTATIN CALCIUM	1.48%
dupilumab SUBCUT 300 MG/2ML SYRINGE	ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST	Non-Preferred; Contact MD or EDS for PA	OZEMPIC	1.97%	FLUTICASONE PROPIONATE	1.37%
cetirizine HCl ORAL 10 MG TABLET	INSULINS		STELARA	1.94%	PANTOPRAZOLE SODIUM	1.29%
pantoprazole sodium ORAL 40 MG TABLET DR	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		LATUDA	1.90%	AMOXICILLIN	1.22%
gabapentin ORAL 300 MG CAPSULE	CONTRACEPTIVES, ORAL		JARDIANCE	1.80%	SERTRALINE HCL	1.20%
insulin glargine,hum.rec.anlog SUBCUT 100/ML (3) INSULN PEN	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		VRAYLAR	1.57%	AMLODIPINE BESYLATE	1.20%
oxycodone HCl/ acetaminophen ORAL 5 MG-325MG TABLET	ANTIMIGRAINE PREPARATIONS		PROAIR HFA	1.39%	ESCITALOPRAM OXALATE	1.12%

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.	Company
a. Identify, by name, your RetroDUR vendor.	Kepro
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.	The RetroDUR vendor is the developer/supplier of the retrospective DUR criteria. Criteria is supplied by Kepro and reviewed by the DUR Board on a quarterly basis.
d. Does your State customize your RetroDUR vendor criteria?	Ad hoc based on state-specific needs
2. How often does your State perform retrospective practitioner-based education?	Monthly
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)?	Monthly
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	Executive Summary This report prepared for the Connecticut Medial Assistance

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.	Program summarizes the top 10 Retrospective Drug Utilization Review (RDUR) interventions as ranked by the number of intervention letters mailed to prescribers during Federal Fiscal Year (FFY) 2022. Intervention letters are mailed to prescribers to encourage appropriate prescribing and improve drug utilization, which will, in turn, prevent possible adverse drug reactions and improve patient outcomes in the targeted recipient population. A total of 10,965 prescriber letters were mailed for the top 10 criteria evaluated. Each letter included a response form, soliciting feedback from the prescriber. Responses are voluntary and a response rate of 13% was achieved for the top 10 criteria reviewed and a response rate of 10% was achieved overall for all interventions performed during FFY 2022. Program Background Kepro currently provides RDUR services for the Connecticut fee-for-service Medicaid population as a subcontractor with Gainwell Technologies. In an effort to promote appropriate prescribing and utilization of medications, Kepro evaluates claims data against selected criteria monthly to identify recipients with drug therapy issues and mails the corresponding educational intervention letters to those recipients' prescribers. A copy of the recipient's complete drug and diagnosis history, including medications prescribed by other providers, is also provided with the letter. Prescribers have the opportunity to review the entire drug and diagnosis history and make changes to therapies based on this information. Analysis Methodology Each month Kepro evaluates Connecticut fee-for-service Medicaid pharmacy claims data against criteria for several hundred potential drug therapy issues. Criteria are developed by Kepro and presented to the Connecticut Drug Utilization Review Board for approval and implementation. Recipient Selection The drug history and diagnosis profile for each recipient who meets the selected criteria are reviewed by a Kepro clinical pharmacist to determine if the recipient should be selected for intervention. After recipients are selected for intervention, educational intervention letters are mailed to all prescribers of drugs included in the criteria. Letters are sent with a complete drug history and all diagnoses obtained from claims data submitted during the past 6 months. Some letters cannot

	be mailed or are returned after mailing due to missing or invalid provider addresses. Once a recipient is selected for intervention, the specific criteria are suppressed by the RDUR system for that recipient for 6 months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, recipients could be selected for additional criteria exceptions later in the year. Recipients may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle. Retrospective DUR Intervention Summary The table below is a summary of educational outreach letters mailed for the top 10 retrospective DUR interventions based on number of letters mailed for FFY 2022. CRITERIA TYPE, CRITERIA DESCRIPTION, # OF CASES CREATED, # INTERVENTION LETTERS MAILED TO PRESCRIBERS, # PRESCRIBER RESPONSES LI, Connecticut lock-in (LI) criteria, 1274, 3593, 398 DD, Co-administration of opioids and benzodiazepines should be done with extreme caution as the combination may result in respiratory depression, hypotension, profound sedation, coma, and death. If concurrent administration is clinically warranted, consider dosage reduction of one or both agents. Re-evaluate the patient's treatment plan on a regular basis to determine the necessity for continued concomitant use of these agents. The SUPPORT Act of 2018 requires that Medicaid monitor the concurrent use of opioids and benzodiazepines. , 940, 1450, 215 TA, All children and adolescents on stimulant medications should have routine follow-up studies and monitoring every 3 months for blood pressure, pulse, weight, height, and BMI/BMI percentile. , 1390, 1353, 296 DD, The concurrent use of an opioid with an antipsychotic may cause hypotension, profound sedation, respiratory depression, coma, and death. Because of these risks, reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate. If co-administration is required, consider dosage reduction of one or both agents. The SUPPORT Act of 2018 requires that Medicaid monitor the concurrent use of opioids and antipsychotics. , 682, 1334, 176 TA, Clinical trials have not shown Lyrica (pregabalin) to be superior to gabapentin for the treatment of neuropathic

	pain associated with diabetic peripheral neuropathy, postherpetic neuralgia or partial-onset seizures in adults. If no contraindications are present consider prescribing the less expensive generic agent, gabapentin, as first-line therapy. , 666, 665, 76 TA, Females of reproductive potential should be informed to discontinue the use of Ozempic (semaglutide) at least 2 months before a planned pregnancy due to the long washout period for semaglutide. , 663, 663, 71 TA, Our records indicate your patient is receiving a proton pump inhibitor (PPI) chronically. PPIs are very effective agents but are not without adverse effects, especially with long-term use. The agents have been associated with increased risk of Clostridium difficile, bone fractures, vitamin B-12 deficiency, hypomagnesemia, fund gland polyps, and hospital- and community-acquired pneumonia. Consider the risks and benefits of proton pump inhibitor therapy and fully inform patients of side effects before prescribing. , 553, 553, 34 DD, The combination of first-generation antihistamines and CNS depressants should be done with caution due to potentiation of sedative action caused by CNS depressants. , 380, 475, 34 TA, Immediate-release opioids should be reserved for pain severe enough to require opioid treatment for which alternative treatment options such as non-opioid analgesics are inadequate or not tolerated. These agents expose patients to the risks of opioid addiction, abuse, and misuse, potentially harmful interactions, and adverse effects on the endocrine system. Prolonged use of immediate-release opioids in pregnant women can also result in NOWS (neonatal opioid withdrawal syndrome)., 412, 450, 53 TA, Our records do not indicate an FDA-approved supporting diagnosis for the use of aripiprazole. Although evidence supports the use of antipsychotics in youth for certain narrowly defined conditions, the majority of children on antipsychotics do not have one of these conditions. The AHRQ CHIPRA Pediatric Quality Measures Program (PQMP) recommends psychosocial care as first-line treatment before utilizing antipsychotic medications in this population. Antipsychotics have serious, common adverse effects including weight gain, hyperprolactinemia, and metabolic disturbances. , 434, 429, 32 , Total Top 10, 7,394, 10,965, 1,385 , Total all letters for all criteria, 19,439, 24,423, 2,561

	LI-Lock In, TA-Therapeutic Appropriateness, DD-Drug Drug Interaction Prescriber Response Tabulation In addition to the intervention letter and the recipient's drug and diagnosis history, a response form is included in the mailings. The response form allows prescribers to give feedback and informs Kepro if any action will be taken in response to the letter. The response form contains standard responses that allow the provider to check a box for the response that best fits their intended action and provides space for handwritten comments. Providers are encouraged to return the response form using the self-addressed, stamped envelope included with the intervention letter or send the form via fax. Kepro tracks all returned response forms. Results Provider Responses to Intervention Letters A total of 10,965 DUR educational intervention letters were mailed for the top 10 interventions to prescribers during FFY 2022, however, a total of 24,423 letters were mailed for all interventions performed during FFY 2022. 2,561 responses were received during FFY 2022 for a total response rate of 10%. A summary of all coded responses from prescribers is listed in the table below. Prescriber Response, Total BENEFITS OF THE DRUG OUTWEIGH THE RISKS, 198 MD UNAWARE OF WHAT OTHER MD PRESCRIBING, 41 PT IS NO LONGER UNDER THIS MD's CARE, 139 MD SAYS PROB INSIGNIF NO CHG THX, 1,214 MD WILL REASSESS AND MODIFY DRUG THERAPY, 160 MD TRIED TO MODIFY THERAPY, PT NON-COOP, 70 PT UNDER MY CARE BUT NOT SEEN RECENTLY, 75 PATIENT DECEASED, 4 PATIENT WAS NEVER UNDER MD CARE, 20 HAS APPT TO DISCUSS THERAPY, 283 MD DID NOT RX DRUG ATTRIBUTED TO HIM, 125 TRIED TO MODIFY THERAPY,SYMPTOMS RECURRED, 73 MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD, 158 BENEFIT OUTWEIGHS RISK,NO CHANGE RECOMMENDED, 1 Total responses for FFY 2022, 2,561 Response Rate, 10% Conclusion The top 10 interventions to prescribers were conducted for

	the Connecticut Medical Assistance Program population during FFY 2022 which resulted in 7,394 cases created, 10,965 prescriber letters mailed, and 1,385 responses received. The response rate for the top 10 interventions, was 13% during FFY 2022.

Section IV - DUR Board Activity

Question	Response
1. Does your State have an approved Medication Therapy Management (MTM) Program?	No
2. Summary 2 – DUR Board Activities DUR Board Activities Summary should be a brief descriptive on DUR activities during the fiscal year reported.	Summary 2 is a brief descriptive report on DUR Board activities during FFY 2022. This summary should: - Indicate the number of DUR Board meetings held. Four DUR Board meetings were held during FFY 2022; December 2021, March 2022, June 2022, and September 2022. See link below for meeting minutes. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Minutes.pdf DUR BOARD MEMBERSHIP - 10/01/2021 to 12/31/2021 Kenneth Fisher, R.Ph. (Chair), Dennis Chapron, M.S., R.Ph., Richard Gannon, Pharm.D., Keith Lyke, R.Ph., Bhupesh Mangla, M.D., MPH., Ram Illindala, M.D., Carol Drufva, R.Ph., Angela Boggs, Pharm.D. BCPP DUR BOARD MEMBERSHIP - 1/01/2022 to 06/30/2022 Kenneth Fisher, R.Ph. (Chair), Dennis Chapron, M.S., R.Ph., Richard Gannon, Pharm.D., Keith Lyke, R.Ph., Bhupesh Mangla, M.D., MPH., Ram Illindala, M.D., Carol Drufva, R.Ph., Angela Boggs, Pharm.D. BCPP, Lacey Whitmire, M.D. DUR BOARD MEMBERSHIP - 7/1/2022 to 09/30/2022 Keith Lyke, R.Ph. (Interim-Chair), Dennis Chapron, M.S., R.Ph., Richard Gannon, Pharm.D., Bhupesh Mangla, M.D., MPH., Ram Illindala, M.D., Carol Drufva, R.Ph., Angela Boggs, Pharm.D. BCPP, Lacey Whitmire, M.D. - List additions/deletions to DUR Board approved criteria. 1. For prospective DUR, list problem type/drug combinations added or deleted. No Prospective DUR criteria were added, deleted or modified during FFY 2022 by the DUR Board.

Question	Response
	2. For retrospective DUR, list therapeutic categories added or deleted. See recommended criteria below. - Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. No specific Board policies were in place for the coordination of prospective and retrospective DUR screenings. The Retrospective DUR vendor, Kepro account representatives attended DUR Board meetings and RetroDUR criteria were proposed to the Board. It has always been standard practice for the state of Connecticut to expect that the Retrospective DUR vendor would be familiar with and report any pharmacy who was consistently overriding ProDUR alerts through the retrospective review of client-specific, prescriber, and most certainly pharmacy-specific profiling reviews. The RetroDUR vendor was aware of the ProDUR criteria and the clinical review pharmacists kept the ProDUR criteria in mind with each client-specific profile review. Retrospective DUR screens have always been used by the state of Connecticut, Department of Social Services to help in establishing new cost-containment and appropriate therapy policies and programs, including changes to ProDUR edits when necessary. If pharmacies are found to be overriding ProDUR criteria excessively then the problem is investigated for creative solutions. - Describe DUR Board involvement in the DUR education program. (e.g., newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring). The quantities of RetroDUR intervention types are set

Question	Response
	contractually by CT Medical Assistance Program Department of Social Services. The DUR vendor reviews prescription drug history and diagnosis claims data to perform monthly interventions. Numbers and types of interventions are included in summary 2. The contractor is required to review 2,000 patient profiles per month for the regular RetroDUR program based upon criteria approved by the DUR Board. 1,000 monthly profiles focus on an adult intervention and 1,000 monthly profiles focus on a pediatric intervention. Separate from the RetroDUR program is the Lock-In Program. For the Lock-In Program, the contractor is required to review 800 patient profiles per month. The contractor is required to conduct educational interventions with prescribers based upon criteria involving overuse of drugs with potential for abuse, doctor shopping, and pharmacy shopping. Patients are warned and if their excessive use does not change within 90 days, the recipients are locked-in to one pharmacy for one year, at which time their drug usage is re-evaluated. The criteria reviewed by the DUR Board during FFY 2022 are included in Summary 2 including which criteria were approved, tabled, or rejected. Four educational newsletters were mailed to targeted prescribers and pharmacies during FFY 2022. See link below for DUR newsletters. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Newsletters.pdf

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?	No
If "No," does your State have a plan to include this information in your DUR criteria in the future?	No
2. RetroDUR?	No
If "No," does your State have a plan to include this information in your DUR criteria in the future?	No

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.	Currently the Connecticut DUR Board has no specific written policies concerning the use of generics. The DUR Board does encourage prescribers to consider judicious, wise use of limited public Medicaid funds while providing quality treatment. The Board does not feel that judicious use of funds and quality care are diametrically opposing goals. Prior to October 2002, the Connecticut Department of Social Services Medical Assistance pharmacy program had no specific policies, but encouraged the use of generics through: 1.) Educational monographs issued to the prescribing and dispensing providers, and 2.) Applying a $0.50 generic substitution incentive professional dispensing fee to prescriptions filled by licensed pharmacies for generic drugs dispensed to Medicaid recipients. Effective 10/1/02, pursuant to Section 50 of General Assembly Bill 6004 of the May 9, 2002 Special Legislative Session, the $0.50 generic substitution incentive professional dispensing fee applied to prescriptions filled by licensed pharmacies for generic drugs dispensed to Medicaid recipients was repealed. Current Connecticut Department of Social Services Medical Assistance pharmacy program policies designed to encourage the use of generics and to promote generic substitution are: 1.) NADAC Pricing List: Effective April 1, 2017, the Connecticut Medical Assistance Program implemented a new drug pricing methodology using National Average Drug Acquisition Cost (NADAC) files. This change was made in compliance with the Patient Protection and Affordable Care Act of 2010. NACAC pricing is based on the average acquisition cost for covered outpatient drugs. a. Pharmacy claims were updated to price using NADAC values for dispense dates on or after April 1, 2017. Brand name single source and multisource drugs reimburse

Question	Response
	at the Brand NADAC price while generic drugs reimburse at the Generic NADAC price. Claims for drugs without a NADAC price will reimburse at the lesser of the Federal Upper Limit (FUL) or the Wholesale Acquisition Cost (WAC) with the following exceptions, which will always reimburse at WAC: i. Preferred brand name medications (as identified on the Preferred Drug List (PDL), and ii. Medications submitted with a Dispense as Written (DAW) Code of 1 (Substitution Not Allowed-Brand Medically Necessary), for all HUSKY A, HUSKY C, HUSKY D, TB AND FAMPL recipients. 2.) FUL Pricing List: DSS previously adopted the federal upper limit (FUL) list for pricing which helps to promote generic substitution. 3.) WAC Pricing List: Effective 4/1/2017, the average wholesale price (AWP) pricing segment is only being used to calculate the WAC rate for reimbursement when an NDC has no NADAC rate on file. The WAC rate is calculated by dividing the AWP rate by 1.2. 4.) State MAC Pricing List: The SMAC Program was end dated on 3/31/2017 with the implementation of NADAC Pricing changes to pharmacy reimbursement. 5.) Prior Authorization for Brand Drugs when 2 Generic Equivalents are available: Prior authorization is required if a prescriber believed that a documented clinical reason existed for a client to receive a brand name drug (Brand Medically Necessary) when two generic drug products plus brand that the FDA considered to be therapeutically equivalent, A-rated, was available. Exemptions: PA is not required for: A.) Compounded claims, B.) Brand name atypical antipsychotics for recipients who have had this medication filled within the last year; C.) HIV medications and D.) Non-maintenance medications prescribed for less than a 15-day supply E.) Cyclosporine or Levothyroxine products (due to the narrow therapeutic window). 6.) Preferred Drug List: While generics are preferred for most therapeutic classes, there are some instances where the brand is preferred over the generic because of the net-net cost to the state.

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, Require that a MedWatch Form be submitted
If "Other," please explain.	A BMN PA is required unless the brand name drug is on the PDL. A DAW-1 submitted on electronic prescriptions is acceptable.

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	1,430,383.00	8,146,558.00	608,523.00
Total Reimbursement Amount Less Co-Pay	$1,420,440,983.00	$193,153,174.00	$224,054,126.00

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	8,146,558
Total Number of Claims	10,185,464
Generic Utilization Percentage	80%
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)?	87
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	$193,153,174
Total Dollars	$1,837,648,283
Generic Expenditure Percentage	11%
6. Does your State have any policies related to Biosimilars? Please explain.	No, our state does not have any policies related to biosimilars.

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	Prospective cost savings by Gainwell Technologies. Retro DUR cost savings by Kepro.
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	$156,524,513.00
RetroDUR Total Estimated Avoided Costs	$3,964,587.00
Other Cost Avoidance	$0.00
Grand Total Estimated Avoided Costs	$160,489,100.00

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 5, then multiplying this value by 100.	8.73%
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

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.	This report prepared for the Connecticut Medical Assistance shows the expected estimated cost savings from implementing a retrospective drug utilization review (RDUR) and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2022 (FFY 2022). The drug claims for the selected recipients were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2021 and September 30, 2022, there was an estimated cost savings of $3,964,587. Table 1 Estimated Cost Savings for FFY 2022 All Interventions Intervention Group Change between 6 Month Pre- and Post- Comparison Group Change between 6 Month Pre- and Post- Estimated Cost Savings All Interventions $1,077,638 ($2,886,949) $3,964,587 During FFY 2022, KEPRO reviewed 17,418 recipients with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Analysis Methodology Each month, KEPRO evaluates pharmacy and medical claims data against a library of clinical criteria. Once recipients have been identified and RDUR letters have been mailed to their providers, KEPRO tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims.

	The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. Beneficiary Selection A total of 33,123 recipients met the criteria for intervention letters during FFY 2022. Estimated Cost Savings Methodology To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. KEPRO then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same recipient within FFY 2022). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Estimated Cost Savings Analyses Results For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, KEPRO evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed . Table 3 shows the results for both the intervention and comparison group for the pre- and post-intervention timeframes for recipients with single and multiple

	interventions during FFY 2022. Table 3 - Estimated Cost Savings for FFY 2022 Intervention Group Change between 6 Month Pre- and Post- Comparison Group Change between 6 Month Pre- and Post- Estimated Cost Savings Single Intervention $2,301,556 ($2,442,324) $4,743,880 Multiple Intervention ($1,223,918) ($444,625) (779,293) Total Estimated Cost Savings $3,964,587 KEPRO found the intervention group had a decrease of 1.13% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 13.34%. These changes resulted in an estimated cost savings of $266.26 per recipient who received an intervention during FFY 2022. Results Discussion All drug claims and some medical claims or diagnosis data is available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems including inappropriate use of drugs and increased risk for drug interactions other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion The RDUR program provides an important educational service to providers enrolled in the Connecticut Medical Assistance. During FFY 2022, 17,418 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $3,964,587 for FFY 2022. 4b PRO-DUR SAVINGS

	PLEASE NOTE: ProDUR Savings Calculation Methodology Savings for Pro-DUR alerts are derived from the soft-edit Pro-DUR alerts. A soft-edit alert notifies the dispensing pharmacist of a potential problem; the pharmacist evaluates the alert based upon the patient's situation and decides whether to override the alert or whether to cancel filling the prescription due to the alert. ProDUR Savings are estimated from the number of cancelled & no response prescriptions after the soft edit alert hits. The cancelled & no response prescriptions are also called the number of denied claims that are reviewed by pharmacists who decide not to fill the prescriptions after hitting a soft edit. Methodology of how Gainwell Technologies calculated the ProDUR savings is either Gainwell Technologies multiplied the number of cancelled & no response prescriptions by the average cost per prescription for each ProDUR Alert type; or, Gainwell Technologies tracked what the cancelled & no response prescriptions would have cost if they had been dispensed. Then each alert type savings were added to create a sum of all savings labeled, Cost Savings Total in Summary 4b. ProDUR Savings ProDUR savings for FFY 2022, as calculated by the claims processor and fiscal agent Gainwell Technologies , was estimated to be a total of $156,524,513 on 4,470,977 prescriptions for patients. ALERT TYPE, # of Claims Cost Savings, Reporting the year of 10/01/2021 09/30/2022, Reporting the year of 10/01/2021 09/30/2022 , , , , , Total # of Claims, Total Cost Savings Drug-Drug, Rx, 137,540, DD, $, , $1,387,183 Early Refill, Rx, 2,817,393, ER, $, , $134,888,657 High Dose, Rx, 13,638, HD, $, , $94,338

Question	Response
	Ingredient Duplication, Rx, 1,135,711, ID, $, , $16,923,294 Drug-Age, Rx, 4,072, PA, $, , $11,916 Drug-Pregnancy, Rx, 35,075, PG, $, , $189,761 Therapeutic Duplication, Rx, 327,548, TD, $, , $3,029,364 , , , TOTALS, Rx, 4,470,977, , $, , $156,524,513

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)?	Deny claims, Other, Refer to Lock-In Program, Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation, Require prior authorization (PA)
If "Other," please explain.	A referral form exists in order to refer beneficiaries, pharmacies, or providers that may be committing potential FWA of controlled and non-controlled drugs.
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)?	Days' supply of CS, Other
If "Other," please explain.	It is required by state law that providers check the PDMP prior to prescribing more than a 72 hour supply of a controlled substance.
b. Does your State have the capability to restrict the beneficiary to:	
i. Prescriber only	No
ii. Pharmacy only	Yes
iii. Prescriber and Pharmacy	No
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?	0.0200%
e. Please provide an estimate of the savings attributed to the lock-in program for the fiscal year under review.	$65,896.00

Question	Response
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 the appropriate Medical Board, Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation, Other, Deny claims written by this prescriber
If "Other," please explain.	A referral form exists in order to refer beneficiaries, pharmacies, or providers that may be committing potential FWA of controlled and non-controlled drugs.
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)?	Deny claim, Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation, Other, Refer to Board of Pharmacy
If "Other," please explain.	A referral form exists in order to refer beneficiaries, pharmacies, or providers that may be committing potential FWA of controlled and non-controlled drugs.
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.	A referral form exists to allow the clinical pharmacist to document suspected fraud and abuse of controlled and non-controlled drugs by beneficiaries, pharmacies and prescribers and send the referral form to the DSS program integrity unit for referral or further review.
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?	Yes
If "No," please explain.	N/A
If "Yes," please continue. a. How does your State access the PDMP database (multiple responses allowed)?	Direct access to the database
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).	Can query by client
a. Please explain how the State applies this information to control FWA of controlled substances.	State law requires all prescribers to review a patient's controlled substance history report if writing for more than a 72-hour supply. The provider agreement with the agency requires prescribers to adhere to all state laws and regulations. In cases where FWA is suspected the QA department can query the database and open cases for investigations.
b. Does your State also have access to contiguous States' PDMP information?	Yes
c. Does your State also have PDMP data integrated into your point of sale (POS) edits?	No
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.	Provider bulletin, DUR letter, Other
If "Other," please explain.	It is required by state law that providers check the PDMP prior to prescribing more than a 72 hour supply of a controlled substance.
If "Yes," please continue. a. Has the State specified protocols for prescribers checking the PDMP?	Yes

Question	Response
If “Yes,” please explain.	Public Act 16-43 became effective 7/1/2016. Whenever a prescribing practitioner prescribes greater than a 72-hour supply of any Schedule V controlled substance for the treatment of any patient, such prescriber, or such prescriber's authorized agent, shall review, not less than annually, the patient's records in the CPMRS. Public Act 15-198 became effective 10/1/2015. MANDATORY USAGE Prior to prescribing greater than a 72-hour supply of any controlled substance (Schedule II - V) to any patient, the prescribing practitioner or such practitioner's authorized agent shall review the patient's records in the CPMRS at https://connecticut.pmpaware.net. Whenever a prescribing practitioner prescribes controlled substances for the continuous or prolonged treatment of any patient, such prescriber, or such prescriber's authorized agent shall review not less than once every 90 days, the patient's records in the CPMRS. If the CPMRS is not operational, prescriber may prescribe greater than a 72-hour supply of a controlled substance to a patient during the time that the system is down as long as the prescriber or prescriber's authorized agent reviews the records of the patient in the CPMRS not more than twenty-four hours after regaining access to the system. Public Act 13-172 was signed into law on June 21, 2013 and became effective immediately. This Public Act will have two direct effects on prescribers in the state of Connecticut. MANDATORY REGISTRATION All prescribers in possession of a Connecticut Controlled Substance Registration issued by the State of Connecticut, Department of Consumer Protection, will be required to register as a user with the Connecticut Prescription Monitoring and Reporting System (CPMRS) at https://connecticut.pmpaware.net.
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

Question	Response
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.	MME, Payor information, name of previous prescribing provider, name of previous pharmacy dispensing, list of pharmacies within the last 12 months, also checks select states outside of CT.
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
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).	Access is restricted to our Medicaid Fraud Unit only.
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?	No
If "Yes," please explain.	N/A

Question	Response
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
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.	30-day supply
If "Other", please specify.	N/A
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

Question	Response
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.	If a patient has a diagnosis of cancer or sickle cell, no quantity restrictions are applicable however, a maximum of a 30-day supply applies. For all other patients, a maximum of 630 MME every 120 days applies. If a patient exceeds 630 MME in a 120 day period, or > 7 day supply, a short acting opioid PA is required. If prior authorization is granted up to a 30 day supply is imposed.
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.	If a patient has a diagnosis of cancer or sickle cell, no quantity restrictions are applicable however, a maximum of a 30-day supply applies. For all other patients, a prior authorization is required. If prior authorization is granted up to a 30-day supply is imposed.
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.	Deny claim and require PA, Require PDMP checks, Intervention letters, MME daily dose program
If "Other," please specify.	N/A
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

Question	Response
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.	The automated retrospective claims review utilizes the lock-in criteria to identify patients and the early refill specific letter (letter type 47) to send notification to prescribers whose patients are identified as receiving early refills or exceeding days supply. CT has automated retrospective claims reviews for identifying recipients receiving duplicate therapy with long acting opioids and short acting opioids. Duplicate therapy criteria negate for malignancy and sickle cell disease. Automated retrospective claims reviews for identifying recipients exceeding quantity limits for solid oral opioids (>240 units per 30 days), liquid oral opioids (>500 ml per 30 days), and injectable opioids (>30 units per 30 days). Quantity limit criteria negate for malignancy and sickle cell disease. These reviews occur monthly during the regular profile review process.
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).	RDUR criteria is designed to target recipients who receive any benzodiazepine (30-day supply in 90 days) concurrently with any opioid (30-day supply in 90 days). An occurrence of any negating diagnosis and/or drug below would negate the criteria from selecting those recipients. Negating medications /diagnoses include antineoplastic agents, malignancy diagnoses, sickle cell, and palliative care. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention annually.
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, both POS edits and automated retrospective claim reviews
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.	Automated retrospective claims review, Provider education
If "Automated retrospective claim reviews" and/or "Yes, provider education," please indicate how often.	Other

Question	Response
If "Other," please specify.	RDUR criteria is designed to target recipients who receive any controlled substance with a diagnosis of medication related poisoning (including illicit substance poisoning) within the previous 180 period. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them about the poisoning and continued use of controlled substances. Additionally, we perform this review as a targeted specialty intervention annually with more specific parameters that target recipients who receive any controlled substance with a diagnosis of poisoning, who also have specific risk factors for overdose including opioid use disorder.
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.	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.	Abuse deterrent opioids are included on the PDL.

Question	Response
If "No," please explain.	N/A
13. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency?	Yes
If "Yes," please explain.	For a portion of the public health emergency, early refill thresholds on controlled substances, including opioids, was relaxed from 93% to 80%.

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?	90 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?).	The maximum MME is defined as exceeding 630 MME in a rolling 120-day window. Patients who exceed these limits will require prior authorization unless their diagnosis is cancer, sickle cell, or if their prescriber is in a hematology/oncology taxonomy. This limit applies to short acting opioid only. All long acting opioids require prior authorization unless their diagnosis is cancer or if their prescriber is in a hematology/oncology taxonomy.
If "No," please explain why not.	N/A
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

Question	Response
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.	CDC
If "Other," please specify.	N/A
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.	Drugs that are grouped in the MAT class are subject to PDL requirements.
If "No," please explain.	Drugs that are grouped in the MAT class are subject to PDL requirements.
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.	Other
If "Other," please explain.	An informational ProDUR high dose alert is set at point of sale for any buprenorphine prescription that exceeds 24 mg per day.

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?	No
If "No," please explain why not.	We currently have RDUR criteria to identify opioids used concurrently with any buprenorphine drug or any form of MAT dispensed at the pharmacy level.
If "Yes," can the POS pharmacist override the edit?	N/A
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, prescribed independently

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.	A referral is not needed for OUD treatment through OTPs.
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.	A quantity limit of 240 units is used for oral tablets. QL of 500 units for liquid, QL of 30 units for injectables.
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, Polypharmacy
Specify child's age limit in years.	18
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antipsychotic monitoring program(s).	Connecticut currently has approximately 40 individual RDUR criteria used to monitor and manage antipsychotic medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly and 1,000 patient profiles are reviewed each month. While there are 12 targeted interventions that occur annually for the pediatric population, antipsychotic medication targeted review and intervention occur at least four times a year. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
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

Question	Response
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):	Child's age, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	18
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented stimulant monitoring program(s).	Connecticut currently RDUR criteria used to monitor and manage stimulant medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly and 1,000 patient profiles are reviewed each month. While there are 12 targeted interventions that occur annually for the pediatric population, stimulant medication targeted review and intervention occur at least once a year. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
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

Question	Response
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):	Child's age, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	18
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antidepressant monitoring program(s).	Connecticut currently RDUR criteria used to monitor and manage antidepressant medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly and 1,000 patient profiles are reviewed each month. While there are 12 targeted interventions that occur annually for the pediatric population, antidepressant medication targeted review and intervention occur at least once a year. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
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

Question	Response
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):	Child's age, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	18
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented mood stabilizer monitoring program(s).	Connecticut currently RDUR criteria used to monitor and manage mood stabilizing medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly and 1,000 patient profiles are reviewed each month. While there are 12 targeted interventions that occur annually for the pediatric population, mood stabilizing medication targeted review and intervention occur at least once a year. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
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

Question	Response
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, Dosage, Indication, Polypharmacy
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).	Connecticut currently RDUR criteria used to monitor and manage anti-anxiety/sedative medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly and 1,000 patient profiles are reviewed each month. While there are 12 targeted interventions that occur annually for the pediatric population, anti-anxiety/sedative medication targeted review and intervention occur at least once a year. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
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

Question	Response
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?	No
If "Yes," please explain.	N/A
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).	Retrospective DUR Innovative Practices Pediatric Reviews There are approximately 1,000,000 patients enrolled in the Connecticut Medical Assistance Program and approximately half of those patients are under the age of eighteen. Beginning July 2010, the Connecticut Medical Assistance Program began performing Retrospective Drug Utilization Review (RDUR) on the Pediatric population in addition to the reviews performed on the adult population. 1,000 monthly reviews are performed on the adult population and 1,000 monthly reviews are performed on the pediatric population. Pediatric Reviews Examples of pediatric reviews performed during FFY 2022 include; stimulant use in patients with comorbid anxiety, risks associated with use of atypical antipsychotics in the pediatric population, therapeutic duplication of antidepressants, pediatric psychotropic medication monitoring for stimulants, NCQA/HEDIS criteria, proton pump inhibitor (PPI) review, additive sedation, pediatric psychotropic medication monitoring for benzodiazepines, pediatric psychotropic medication max dosing, monitoring recommendations for anticonvulsant medications, and antihistamine and steroid criteria review. Adult Reviews Adult drug utilization review has been the foundation of the RDUR program in Connecticut. Select topics of review during FFY 2022 for the adult population included; medication use in renal impairment, atypical antipsychotic use in diabetic patients, SUPPORT Act criteria concurrent opioids and benzodiazepines, utilization of pregabalin over gabapentin for neuropathic pain, underutilization of

Question	Response
	antipsychotics, underutilization of anticonvulsant medications, concurrent use of opioid agonists with partial agonists or antagonists, SUPPORT Act criteria concurrent use of opioids and antipsychotics. Inappropriate therapy in the elderly, Specialty mailer - patients who are receiving chronic opioid therapy without naloxone who have at least 1 risk factor for overdose, and drugs cautioned or contraindicated during pregnancy. Lock-In Program Approximately 5,000 patients are flagged by the lock-in criteria for review each month and 800 patients are reviewed during each monthly cycle. The goal of restricting a patient to a single pharmacy is to ensure that patients have access to medication they need while reducing the harm associated with over utilizing controlled substances. Fraud Hotline The Fraud Hotline at the Department of Social Services (DSS) is a proactive approach to handling complaints regarding fraud and abuse from the community. Complaints received by the fraud hotline are sent to the pharmacy unit at DSS to determine if patients should be placed into selected review for further action. Retrospective DUR Innovative Practices Established during FFY 2022 During December 2021, the DUR Board approved a newsletter titled Hitting a Nerve with the Gabapentinoids. In tandem with the newsletter a targeted intervention was performed in the adult population for utilization of pregabalin over gabapentin for neuropathic pain associated with diabetic peripheral neuropathy, postherpetic neuralgia or partial-onset seizures in adults. During February and March 2022, targeted RDUR interventions were performed on the pediatric population which reviewed NCQA/HEDIS recommendations for use of antipsychotics in the pediatric population. In line with the SUPPORT Act requirements to have a program in place to monitor the use of antipsychotics in this population, the DUR Board proactively approved these criteria as additions to the criteria library used to review and send educational interventions for all recipients in the pediatric population,

Question	Response
	including foster care children. During this intervention 866 unique recipients were targeted, and their prescribers received intervention letters. 6 months post intervention, 352 of the 866 recipients intervened on continued to be flagged by the criteria, resulting in 60% positive response to the intervention. During March 2022, the DUR Board approved a newsletter focusing on Alzheimer's Disease, diagnosis, treatment, and future outlook. This newsletter was sent to all enrolled CT Medicaid providers. During April 2022 a targeted intervention was performed on the adult population for the underutilization of antipsychotics. During this intervention 505 unique recipients were targeted, and their prescribers received intervention letters. 6 months post intervention, 27 of the 505 recipients intervened on continued to underutilize their antipsychotic, resulting in 95% of patients responding positively to the intervention. During June 2022, the DUR Board approved a two-part newsletter titled Affirming Gender Through Clinical Pharmacology. The first part of this newsletter series covered historical aspects, diagnostic criteria, barriers to healthcare that transgender people are faced with, and a review of guideline based pharmacological treatment with Gonadotropin Releasing Hormone analogues (GnRHa). The newsletter was sent to all enrolled CT Medicaid providers. During July 2022, a specialty mailer was performed targeting prescribers of patients receiving greater than or equal to 90 morphine milligram equivalents (MME) per day chronically, without evidence of a current naloxone prescription (within the past six months) and are considered at risk for experiencing an overdose. During this intervention 667 unique recipients were targeted, and their prescribers received intervention letters. During September 2022, the DUR Board approved part two of Affirming Gender Through Clinical Pharmacology. This newsletter focused on guideline-based gender affirming hormone therapy used in the transgender population. The newsletter was sent to all enrolled CT Medicaid providers.

Question	Response
	Prospective DUR Innovative Practices Established during FFY 2022 During March 2022, Tubeless Insulin Pumps (V-Go and Omnipod) were added as covered items with prior authorization under the pharmacy benefit. Additionally, in April 2022, Coverage of Outpatient Dialysis Services under Emergency Medicaid for Non-Citizens was implemented. This coverage included select pharmacy services. Pharmacy point of sales claims submitted require a diagnosis code for patients in this coverage group indicating the drug or product is being dispensed for dialysis or renal disease implications. Additionally, in July 2022, Medically Necessary Prior Authorization was implemented for Dupixent. Dupixent, a costly biologic agent, currently is indicated for Eosinophilic Esophagitis, Uncontrolled Moderate-to-Severe Atopic Dermatitis (Patients aged 6+ months), Moderate-to-Severe Asthma (Patients 6+ years), Inadequately Controlled Chronic Rhinosinusitis with Nasal Polyposis (Patients 18+ years), and Prurigo Nodularis (Patients 18+ years). As such, patients must meet the clinical criteria based on the approved indication for Dupixent to obtain an approved prior authorization. During August 2022, CT Medicaid implemented changes to support pharmacist prescribing and coverage of paxlovid for patients. Pharmacists prescribing paxlovid must follow guidelines as documented in FDA's emergency use authorization. Pharmacists who have an NPI are permitted to submit either their own personal NPI or that NPI of the pharmacy to receive a paid claim.

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.	0
2. Is your pharmacy program included in the capitation rate (carved in)?	N/A
If "Partial, "please check what categories of medications are carved out and handled by your FFS program (multiple responses allowed):	N/A
If "Other," please specify the drug categories.	N/A
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?	N/A
If "Yes," please specify effective date.	N/A
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?	N/A
If "Yes," State is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions. Please explain monitoring activities.	N/A
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)?	N/A
a. If "Yes," check all that apply.	N/A
b. Please briefly explain your policy.	N/A
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?	N/A
6. Indicate how the State oversees the FFS and MCO RetroDUR programs? Please explain oversight process.	N/A
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?	N/A
8. Did all of your managed care plans submit their DUR reports?	N/A
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.	Objectives for the operations of the Connecticut Medical Assistance Drug Utilization Review (DUR) Board during federal fiscal year 2022 include: (1) maintain a DUR Board with membership that meets OBRA 1990 requirements; (2) continue prospective DUR criteria review and evaluation, (3) conduct focused retrospective analyses of claims data to study drug utilization in the Connecticut Medical Assistance Program including the fee-for-service population and to (4) guide the development and implementation of educational interventions to improve drug use in this population. From 10/01/2021 to 9/30/2022 the DUR Board was comprised of six pharmacists and three physicians. Four DUR Board meetings were held during FFY 2022. Twenty-four targeted retrospective analyses were reviewed and approved by the DUR Board and conducted during FFY 2022. All the retrospective evaluations included mailing of recipient specific educational intervention letters to prescribers. Recipient specific educational intervention letters highlight a drug therapy concern and are sent to prescribers with a complete recipient drug and diagnosis history profile along with a response form. An additional 12 retrospective analyses for the pharmacy lock-in program were conducted during FFY 2022. The Pharmacy Lock-In Program is ongoing and Kepro is required to review 800 lock-in profiles monthly. For the future, the DUR Board aims to accomplish the following: (1) provide recommendations to help improve drug therapy in the Connecticut Medical Assistance Program population, (2) analyze the utility and effectiveness of existing prospective DUR criteria and retrospective interventions for the fee-for-service population and patients taking medications reimbursed fee-for-service, (3) recommend and review prescriber interventions and educational programs and (4) serve in an advisory role for the development and management of a Pharmacy Lock-In Program. Cost Savings analyses of both prospective and

Question	Response
	retrospective DUR are reported and can be found in Summary 4 of the CMS Report. The reported cost savings for Retrospective DUR during FFY 2022 from Kepro was $3,964,587. The reported cost savings for Prospective DUR during FFY 2022 was $156,524,513.