



Florida

Medicaid Fee-For-Service (FFS)
Federal Fiscal Year (FFY) 2022
Drug Utilization Review (DUR)
Annual Report

Table of Contents

| | |
|--|-----------|
| Section I - Number of Beneficiaries | 1 |
| 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 |
| 2. On a monthly average, how many of your State's Medicaid beneficiaries are enrolled in managed care plan(s)? .. | 1 |
| Section II - Prospective DUR (ProDUR) | 2 |
| 1. Indicate the type of your pharmacy point of service (POS) vendor. | 2 |
| 2. Identify your ProDUR table driven criteria source..... | 2 |
| 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”? | 2 |
| 4. Does your State receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail? | 2 |
| 5. Early Refill | 3 |
| 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: | 3 |
| 7. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early? ... | 4 |
| 8. Does the State Medicaid program have any policy prohibiting the auto-refill process that occurs at the POS? | 4 |
| 9. Does your system have a diagnosis edit that can be utilized when processing a prescription? | 4 |
| 10. For drugs not on your Preferred Drug List (PDL), does your Medicaid program have a documented process in place, so that the Medicaid beneficiary or the Medicaid beneficiary’s prescriber may access any covered outpatient drug when medically necessary? | 4 |
| 11. Top Drug Claims Data Reviewed by the DUR Board below | 5 |
| 12. Who in your State has responsibility for monitoring compliance with the oral counseling requirement? | 7 |
| Section III - Retrospective DUR (RetroDUR) | 8 |
| 1. Indicate the type of vendor that performed your RetroDUR activities during the time period covered by this report. | 8 |
| 2. How often does your State perform retrospective practitioner-based education?..... | 8 |
| 3. Summary 1 – RetroDUR Educational Outreach | 9 |
| Section IV - DUR Board Activity | 11 |
| 1. Does your State have an approved Medication Therapy Management (MTM) Program? | 11 |
| 2. Summary 2 – DUR Board Activities | 11 |
| Section V - Physician Administered Drugs (PAD) | 15 |
| 1. ProDUR? | 15 |
| 2. RetroDUR? | 15 |
| Section VI - Generic Policy and Utilization Data | 16 |
| 1. Summary 3 – Generic Drug Substitution Policies | 16 |

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

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? 16

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..... 17

4. How many innovator drugs are the preferred product instead of their multi-source counterpart based on net pricing?..... 18

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..... 18

6. Does your State have any policies related to Biosimilars? 18

Section VII - Program Evaluation / Cost Savings / Cost Avoidance19

1. Did your State conduct a DUR program evaluation of the estimated cost savings/cost avoidance? 19

2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below..... 19

3. The Estimated Percent Impact..... 19

4. Does your Medicaid program provide coverage of over-the-counter medications when prescribed by an authorized prescriber?..... 19

5. Summary 4 – Cost Savings/Cost Avoidance Methodology 20

Section VIII - Fraud, Waste and Abuse Detection.....22

A. Lock-In or Patient Review and Restriction Programs22

1. Does your State have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries? 22

2. Does your State have a lock-in program for beneficiaries with potential misuse or abuse of controlled substances?..... 22

3. Does your State have a documented process in place that identifies possible FWA of controlled drugs by prescribers?..... 23

4. Does your State have a documented process in place that identifies potential FWA of controlled drugs by pharmacy providers? 23

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?..... 23

B. Prescription Drug Monitoring Program (PDMP)24

1. Does your Medicaid program have the ability to query the State’s PDMP database? 24

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?..... 24

3. In the State’s PDMP system, which of the following beneficiary information is available to prescribers as close to real-time as possible? 25

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?..... 26

5. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?..... 26

C. Opioids.....26

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

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?..... 26

2. Does your State have POS edits in place to limit the quantity dispensed of opioids? 27

3. Does your State have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids? 27

4. Does your State have POS edits to monitor duplicate therapy of opioid prescriptions?..... 28

5. Does your State have POS edits to monitor early refills of opioid prescriptions dispensed? 28

6. Does your State have comprehensive automated retrospective claim reviews to monitor opioid prescriptions exceeding these State limitations? 28

7. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and benzodiazepines being used concurrently?..... 28

8. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and sedatives being used concurrently? 29

9. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and antipsychotics being used concurrently? 29

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?..... 29

11. Does your State Medicaid program develop and provide prescribers with pain management or opioid prescribing guidelines? 30

12. Does your State have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse? 30

13. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency?..... 30

D. Morphine Milligram Equivalent (MME) Daily Dose 31

1. Have you set recommended maximum MME daily dose measures?..... 31

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? 31

3. Does your State have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed? 31

4. Do you provide information to your prescribers on how to calculate the MME daily dosage or do you provide a calculator developed elsewhere? 31

E. Opioid Use Disorder (OUD) Treatment 32

1. Does your State have utilization controls to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD? 32

2. Does your Medicaid program set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs? 32

3. What are your limitations on the allowable length of this treatment?..... 32

4. Does your State require that the maximum mg per day allowable be reduced after a set period of time? 33

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

5. Does your State have at least one buprenorphine/naloxone combination product available without PA? 33

6. Does your State currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT? 33

7. Is there at least one formulation of naltrexone for OUD available without PA? 33

8. Does your State have at least one naloxone opioid overdose product available without PA? 33

9. Does your State monitor and manage appropriate use of naloxone to persons at risk of overdose? 33

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? 33

F. Outpatient Treatment Programs (OTP) 34

1. Does your State cover OTPs that provide Behavioral Health (BH) and MAT services? 34

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? 34

3. Does your State Medicaid program cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan? 34

4. Does your State Medicaid program cover Methadone for a substance use disorder? 34

G. Psychotropic Medication For Children..... 34

Antipsychotics..... 34

1. Does your State currently have restrictions in place to limit the quantity of antipsychotic drugs? 34

2. Does your State have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children? 35

Stimulants..... 36

3. Does your State currently have restrictions in place to limit the quantity of stimulant drugs? 36

4. Does your State have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children? 36

Antidepressants 37

5. Does your State have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children? 37

Mood Stabilizers 37

6. Does your State have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children?..... 37

Antianxiety/Sedatives 38

7. Does your State have a documented program in place to either manage or monitor the appropriate use of antianxiety/sedative drugs in children?..... 38

Section IX - Innovative Practices 40

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? 40

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

2. Summary 5 – Innovative Practices 40

Section X - Managed Care Organizations (MCOs)..... 42

1. How many MCOs are enrolled in your State Medicaid program? 42

2. Is your pharmacy program included in the capitation rate (carved in)? 42

3. 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? 42

4. Does the State set requirements for the MCO’s pharmacy benefit? 43

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? 43

6. Indicate how the State oversees the FFS and MCO RetroDUR programs? Please explain 43

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? 43

8. Did all of your managed care plans submit their DUR reports? 43

Section XI - Executive Summary 44

1. Summary 6 – Executive Summary 44

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? | 1,118,649 |
| 2. On a monthly average, how many of your State's Medicaid beneficiaries are enrolled in managed care plan(s)? | 4,108,013 |

Section II - Prospective DUR (ProDUR)

| Question | Response |
|--|---|
| 1. Indicate the type of your pharmacy point of service (POS) vendor. | Contractor |
| a. Vendor Name | Magellan Medicaid Administration |
| b. Who processes the State’s National Council for Prescription Drug Programs (NCPDP) transactions? | None |
| 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 |
| 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? | No |
| If “No,” please explain. | ProDUR alerts are an indication of the edits previously established by the DUR Board. The DUR Board makes upfront decisions on whether edits should be overridden at the pharmacy level (based on clinical judgement). The programming is then implemented to reflect soft or hard edits. Therefore, a pharmacist is only able to override those alerts that the Board has pre-determined should be left to their discretion (as soft edits). ProDUR monitoring reports are not generated outside of the standard fiscal monitoring of Medicaid Program Integrity. The Bureau of Medicaid Program Integrity reviews the pharmacy provider activity, not Pharmacy section under the Policy Bureau. |

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

| Question | Response |
|---|--------------------------------|
| a. How often does your State receive reports (multiple responses allowed)? | N/A |
| If "Other," please explain. | N/A |
| b. If you receive reports, does your State follow up with those providers who routinely override with interventions? | N/A |
| If "Yes," by what method does your State follow up (multiple responses allowed)? | N/A |
| If "Other," please explain. | N/A |
| 5. Early Refill | |
| a. At what percent threshold do you set your system to edit? | |
| i. Non-controlled drugs: | 80% |
| ii. Schedule II controlled drugs: | 90% |
| iii. Schedule III through V controlled drugs: | 90% |
| b. For non-controlled drugs, when an early refill message occurs, does 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): | Other |
| If "Other," please explain. | The overrides are not allowed. |

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

| Question | Response |
|---|--|
| 7. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early? | Yes |
| If "Yes," please explain your edit. | Certain classes have accumulation edits (proton pump inhibitors, skeletal muscle relaxants, and controlled substances). The edit counts refills over a particular time frame to prohibit a total accumulation amount. |
| If "No," does your State plan to implement this edit? | N/A |
| 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. | Certain classes and medications have diagnosis edits (e.g., alpha-1 protease inhibitors, anticonvulsants, lidocaine patches, Solaraze gel, Nurtec ODT, Qulipta, and Ubrelyv). The system will look back in medical claims history for a predetermined diagnosis. |
| 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. | Non-preferred medications with set criteria and prior authorization forms are posted on the Agency for Health Care Administration Pharmacy Policy site. Medications that do not have set criteria can be submitted on the miscellaneous prior authorization form. The clinical reviewers have 24 hours to review the prior authorization request and provide a response. |
| If "No," please explain why not. | N/A |

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

| Question | Response |
|--|---|
| 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. | In the event of a natural disaster, the Bureau Chief will selectively open payment to counties under threat. In the event of a fire or catastrophic loss, one early refill per year may be granted for certain non-controlled substances. |
| 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 | MISCELLANEOUS | plan limitations exceeded | EMICIZUMAB-KXWH | 14.87% | divalproex | 2.03% |
| dupilumab | DIABETIC THERAPY | DUR reject error | ANTIHEMOPH.FVIII REC, FC FUSION | 6.26% | albuterol | 1.91% |
| levalbuterol | OTHER ANTIBIOTICS | product/ service not covered - plan/ benefit exclusion | ANTIHEMOPHIL.FVIII, FULL LENGTH | 4.75% | risperidone | 1.78% |
| ustekinumab | BRONCHIAL DILATORS | prior authorization required | CANNABIDIOL (CBD) | 3.37% | levothyroxine | 1.71% |
| rifaximin | ANTINEOPLASTICS | Product/ Service Not Covered For Patient Age | BICTEGRAV/ EMTRICIT/ TENOFOV ALA | 3.27% | atorvastatin | 1.62% |
| elexacaftor/ tezacaftor/ ivacaftor | ANTIARTHRITICS | | FACTOR IX REC, FC FUSION PROTN | 3.03% | trazodone | 1.61% |
| EVOLOCUMAB | ALL OTHER DERMATOLOGICALS | | adalimumab | 2.99% | levetiracetam | 1.56% |
| apremilast | ANTIVIRALS | | ANTIHEMOPHILIC FACTOR/ VWF | 2.77% | quetiapine | 1.54% |
| deferasirox | LIPOTROPICS | | FACTOR IX RECOM, ALBUMIN FUSIO | 1.97% | amlodipine | 1.45% |
| glecaprevir/ pibrentasvir | MUSCLE RELAXANTS | | ELEXACAFtor/ TEZACAFtor/ IVACAFtor | 1.80% | gabapentin | 1.45% |

| 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, State Board of Pharmacy |
| 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. | Magellan Medicaid Administration |
| 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? | No |
| Please explain "Yes" or "No" response. | The developer of the retrospective DUR criteria is provided by the State DUR Board in collaboration with the Agency and Magellan Medicaid Administration. |
| 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? | Other |
| If "Other," please specify. | Retrospective practitioner-based education is determined by the DUR Board in collaboration with the Agency and can occur at varying intervals depending on topic discussion. |
| a. How often does your State perform retrospective reviews that involve communication of client-specific information to healthcare practitioners (multiple responses allowed)? | Other |
| If "Other," please specify. | Retrospective practitioner-based education is determined by the DUR Board in collaboration with the Agency and can occur at varying intervals depending on topic discussion. |
| b. What is the preferred mode of communication when performing RetroDUR initiatives (multiple responses allowed)? | Newsletters or other non-direct provider communications, Near real-time messaging, Focused workshops, case management, or WebEx training |
| If "Other," please specify. | N/A |

3. Summary 1 – RetroDUR Educational Outreach

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.

1. Review utilization of antipsychotic medication in children.
 - a. As required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, the DUR Board reviewed utilization of antipsychotic medication in children during the December 2021 DUR Board meeting.
2. Review trends in opiate recipients that received naloxone and had an emergency room visit for opiate overdose.
 - a. During the December 2021 DUR Board meeting, the DUR Board reviewed safety outcomes for recipients that had an opiate overdose.
3. Review recipients receiving gabapentin without a supported indication for use in their health conditions.
 - a. During the December 2021 DUR Board meeting, the DUR Board reviewed recipients on gabapentin without a supported indication for use in their health conditions.
4. Review utilization trends for sickle cell therapy.
 - a. During the December 2021 and March 2022 DUR Board meeting, the DUR Board discussed sickle cell therapy utilization related to hospital admissions and health outcomes.
5. Review the post-impact of the Lyrica automated prior authorization.
 - a. During the December 2021 DUR Board meeting, the DUR Board reviewed the post impact of the Lyrica automated prior authorization (based on FDA approved indications). The edit deployed on 12/04/2020.
6. Review utilization of COVID-19 vaccines.
 - a. During the December 2021 DUR Board meeting, the DUR Board reviewed utilization of COVID-19 vaccines.
7. Review Chantix utilization, claim denials, and retreatment.
 - a. During the March 2022 DUR Board meeting, the DUR Board reviewed Chantix utilization over the last 5 years and agreed with the updated criteria.
8. Review opiates and antipsychotics overlap.
 - a. During the March 2022 DUR Board meeting, the DUR Board reviewed recipients on opiates and antipsychotics concomitantly as required by the SUPPORT Act. There is currently a soft edit deployed to monitor/manage use of concomitant therapy.
9. Review long-acting opiates and benzodiazepine overlap.
 - a. During the June 2022 DUR Board meeting, the DUR

Board reviewed recipients on long-acting opiates and benzodiazepines concomitantly. There is currently an edit in place to monitor/manage use of concomitant therapy.

10. Review Hepatitis C treatment utilization over 7 years.
 - a. During the September 2022 DUR Board meeting, the DUR Board reviewed Hepatitis C utilization over 7 years and reviewed retreatment trends.

Section IV - DUR Board Activity

| Question | Response |
|---|--|
| 1. Does your State have an approved Medication Therapy Management (MTM) Program? | Yes |
| <p>2. Summary 2 – DUR Board Activities</p> <p>DUR Board Activities Summary should be a brief descriptive on DUR activities during the fiscal year reported.</p> | <p>The Drug Utilization Review (DUR) Board reviews and approves drug use criteria and standards for both prospective and retrospective drug use reviews. It applies these criteria and standards in the application of DUR activities. The goal of the Florida Medicaid DUR program is to promote appropriate prescribing and use of medications.</p> <p>Magellan Medicaid Administration's ProDUR system is an integrated component of the online, real-time point of sale (POS) system. It compiles both medical and pharmacy claims data into comprehensive online beneficiary health summaries. Pharmacy claims are evaluated according to approved criteria against each member's summary. Claims history includes current, historical, paid, and denied claims data, regardless of the media source of the claims submission. The real-time evaluation of POS claims permits identification of drug therapy problems prior to dispensing.</p> <p>The RetroDUR utilization analyses, as described below, provides information which assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians to potential drug therapy problems, identifies opportunities to improve drug therapy and makes recommendations to avoid drug therapy problems.</p> <p>The ongoing operation of the RetroDUR program is a shared responsibility of Magellan Medicaid Administration, a Magellan Medicaid Administration Company, and the Agency for Health Care Administration (Agency). Each quarter, specific therapeutic areas that have been approved by the DUR Board are targeted for focused review under the RetroDUR program. Magellan Medicaid Administration applies the specified criteria established by the Board to the prescription and health claims files and identifies medication regimens that violate the criteria. Results of analyses are provided to the Board during quarterly meetings. Electronic educational letters are created by Magellan Medicaid Administration, regarding</p> |

| Question | Response |
|----------|---|
| | <p>targeted criteria. Letters are reviewed and approved by the DUR Board and the Agency. The electronic letters are posted to a designated provider alert area of the Agency's website for the provider community. (http://ahca.myflorida.com/medicaid/Prescribed_Drug/banners.shtml).</p> <p>With enhanced technology, Magellan Medicaid Administration offered the DUR Board the ability to provide recommendations to the Agency for POS edits to assist in the mission of the Board, which include educating physicians and positively impacting prescribing for Florida Medicaid recipients. The DUR Board reviews the potential edits and makes recommendations based on their clinical expertise and knowledge. DUR Board members frequently collaborate with colleagues regarding drug utilization issues and bring the results of those discussions back to the DUR Board for consideration.</p> <p>The Florida Medicaid DUR Board met four times during the Federal Fiscal Year 2022. During this timeframe, Magellan Medicaid Administration recommended RetroDUR criteria associated with drug to drug interactions, inappropriate dosing, therapeutic duplication, polypharmacy, safety precautions and overutilization of medications.</p> <p>Magellan Medicaid Administration produces a monthly newsletter/Clinical Alert to educate the provider community about the most recent issues in the pharmaceutical industry and new drug information. These newsletters are available on the Magellan Medicaid Administration website and can be accessed at: https://www1.magellanrx.com/magellan-rx/publications/pharmacy-clinical-alerts.aspx</p> <p>Summary of DUR Board activities:</p> <ol style="list-style-type: none"> 1. Review the top 20 therapeutic classes by claims volume and expenditure to identify appropriate therapies and intervention opportunities including an in-depth review of the miscellaneous class. The DUR Board reviewed a year-to-year comparison to monitor therapeutic class trends. 2. Review utilization of antipsychotic medication in children. As required by the Substance Use-Disorder |

| Question | Response |
|----------|---|
| | <p>Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, the DUR Board reviewed utilization of antipsychotic medication in children during the December 2021 DUR Board meeting.</p> <p>3. Review trends in opiate recipients that received naloxone and had an emergency room visit for opiate overdose. During the December 2021 DUR Board meeting, the DUR Board reviewed safety outcomes for recipients that had an opiate overdose.</p> <p>4. Review recipients receiving gabapentin without a supported indication for use in their health conditions. During the December 2021 DUR Board meeting, the DUR Board reviewed recipients on gabapentin without a supported indication for use in their health conditions.</p> <p>5. Review utilization trends for sickle cell therapy. During the December 2021 and March 2022 DUR Board meeting, the DUR Board discussed sickle cell therapy utilization related to hospital admissions and health outcomes.</p> <p>6. Review the post-impact of the Lyrica automated prior authorization. During the December 2021 DUR Board meeting, the DUR Board reviewed the post impact of the Lyrica automated prior authorization (based on FDA approved indications). The edit deployed on 12/04/2020.</p> <p>7. Review utilization of COVID-19 vaccines. During the December 2021 DUR Board meeting, the DUR Board reviewed utilization of COVID-19 vaccines.</p> <p>8. Review Chantix utilization, denials, and retreatment. During the March 2022 DUR Board meeting, the DUR Board reviewed Chantix utilization over the last 5 years and agreed with the updated criteria.</p> <p>9. Review opiates and antipsychotics overlap. During the March 2022 DUR Board meeting, the DUR Board reviewed recipients on opiates and antipsychotics concomitantly as required by the SUPPORT Act. There is currently a soft edit deployed to monitor/manage use of concomitant therapy.</p> <p>10. Review long-acting opiates and benzodiazepine overlap. During the June 2022 DUR Board meeting, the DUR Board reviewed recipients on long-acting opiates and benzodiazepines concomitantly. There is currently an edit in place to monitor/manage use of concomitant therapy.</p> <p>11. Review Hepatitis C treatment utilization over 7 years. During the September 2022 DUR Board meeting, the</p> |

| Question | Response |
|----------|--|
| | <p>DUR Board reviewed Hepatitis C utilization over 7 years and reviewed retreatment trends.</p> <p>12. Review recipients that received more than one influenza vaccine per season. During the December 2021 DUR Board meeting, the DUR Board reviewed recipients than received more than one influenza vaccine per season. The DUR Board requested a review of pharmacy outliers.</p> <p>13. Review glucocorticoids inhaled therapy. During the March 2022 DUR Board meeting, the DUR Board reviewed glucocorticoids inhaled therapy for utilization and expenditure trends.</p> <p>14. Review therapeutic class utilization and expenditure. During the June 2022 DUR Board meeting, a guest speaker from the Pharmaceutical & Therapeutics (P&T) Committee spoke to the DUR Board regarding therapeutic class expenditure and PDL procedures.</p> <p>15. Review utilization of Entresto. During the September 2022 DUR Board meeting, the DUR Board reviewed Entresto utilization by dosage. The DUR Board will continue to review topic.</p> <p>16. Review utilization of systemic contraceptives. During the September 2022 DUR Board meeting, the DUR Board reviewed systemic contraceptive utilization including a review of utilization by age.</p> <p>Summary of additions/deletions to DUR Board approved criteria:</p> <p>The DUR Board reviewed Chantix utilization and agreed upon updated criteria.</p> <p>The DUR Board approved the proposed growth hormone criteria changes with the addition of the gastroenterologist is limited to adults with short bowel syndrome.</p> <p>The DUR Board reviewed the Hepatitis C criteria and voted to remove the sobriety requirements (urine drug screening) while adding statement that the patient is referred to substance use disorder treatment or counseling within the retreatment criteria.</p> |

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? | Yes |
| 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 |
|--|---|
| <p>1. Summary 3 – Generic Drug Substitution Policies</p> <p>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.</p> | <p>Florida Medicaid has a prescribed-drug spending-control program that includes the Medicaid preferred drug list (PDL). The PDL is a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee. The primary goal of this Committee is to ensure availability of medications that are safe, efficacious, and cost-effective, via the PDL, to Florida Medicaid recipients.</p> <p>In many cases, generic drug utilization is encouraged as the most suitable medication for recipients. The Florida Agency for Health Care Administration is authorized to seek any federal waivers necessary to implement cost-control programs and to continue participation in the federal Medicaid rebate program. Due to the participation in the federal and supplemental rebate program, occasionally Florida Medicaid is afforded the opportunity to realize more cost savings when a branded product is dispensed versus the generic counterpart. In those instances, the branded product is included on the PDL and the generic is excluded. Florida Medicaid also promotes generic substitution through point of sale edits such as requiring a clinical prior authorization for any branded drug for which there is a generic available and implementation of a maximum allowable cost (MAC) program. Florida Medicaid continues to encourage generic substitution when possible. This is demonstrated by Florida Medicaid's generic utilization rate of 85% for Federal Fiscal Year 2022.</p> |
| <p>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?</p> | <p>No</p> |
| <p>If “Yes,” check all that apply.</p> | <p>N/A</p> |
| <p>If “Other,” please explain.</p> | <p>N/A</p> |

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 | 106,664.00 | 847,673.00 | 40,254.00 |
| Total Reimbursement Amount Less Co-Pay | \$258,690,530.59 | \$18,697,295.11 | \$16,667,119.52 |

| 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 | 847,673 |
| Total Number of Claims | 994,591 |
| Generic Utilization Percentage | 85% |

| Question | Response |
|---|---|
| 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)? | 77 |
| 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 | \$18,697,295 |
| Total Dollars | \$294,054,945 |
| Generic Expenditure Percentage | 6% |
| 6. Does your State have any policies related to Biosimilars? Please explain. | Biosimilar products are reviewed during the therapeutic class review quarterly at the Pharmaceutical and Therapeutics (P&T) Committee meetings. |

Section VII - Program Evaluation / Cost Savings / Cost Avoidance

| Question | Response |
|--|----------------------------------|
| <p>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.</p> | Yes |
| Institution Type | Company |
| Institution Name | Magellan Medicaid Administration |
| 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 | \$237,599,811.00 |
| RetroDUR Total Estimated Avoided Costs | \$13,631.00 |
| Other Cost Avoidance | \$2,519,683.00 |
| Grand Total Estimated Avoided Costs | \$240,133,125.00 |

| Question | Response |
|---|----------|
| <p>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.</p> | 81.66% |
| <p>4. Does your Medicaid program provide coverage of over-the-counter medications when prescribed by an authorized prescriber?</p> | Yes |
| If "No," please explain why not. | N/A |

| Question | Response |
|---|---|
| <p>5. Summary 4 – Cost Savings/Cost Avoidance Methodology</p> <p>Cost Savings/Cost Avoidance Methodology Summary should include program evaluations/cost savings estimates prepared by the State or contractor.</p> | <p>Maximum Allowable Cost The Maximum Allowable Cost (MAC) program establishes a maximum price per unit at which Florida Medicaid will reimburse pharmacy providers for generic medications. By using the MAC price, the Medicaid Program reimburses at the same rate for the included products. This enables pharmacy providers to select the agent that is most effective for them without disadvantaging the Medicaid Program.</p> <p>MAC program savings are calculated by re-pricing each claim that paid at MAC as if the MAC price had not existed at the point of adjudication. MAC savings is the difference between the MAC price and the recalculated payment amount. During FFY 2022, the MAC program provided savings of \$2,658,329.91.</p> <p>Preferred Drug List (PDL) Supplemental rebates are collected from pharmaceutical manufacturers for their inclusion as a preferred product. Additionally, market shift savings are generated by shifting the market from more expensive, non-preferred products to less expensive, preferred products. The total savings provided by the PDL program during FFY 2022 was \$7,842,170.</p> <p>Retrospective DUR For all edits or criteria approved by the DUR Board, a pre-implementation analysis is conducted demonstrating the number of claims, number of recipients, and total amount paid that would be impacted by such an edit or criteria. At a reasonable amount of time after implementation of the edit or criteria, a post-implementation analysis is performed demonstrating the number of claims, number of recipients and total amount paid for a similar period of time. The standard post implementation analysis is conducted three months after deployment of the edit but may vary depending on the nature of the edit and the time needed to measure an impact. For example, if an edit allows for a six-month window before claims denial, the impact of the edit would not be assessed until approximately nine months after the edit is deployed. The cost savings is considered to be the difference in the total amount paid between the pre-implementation and the</p> |

| Question | Response |
|----------|--|
| | <p>post-implementation. These figures are then annualized to calculate the RetroDUR cost savings impact. The total savings measured at the time of report submission for RetroDUR edits in FFY2022 was \$13,631.40.</p> <p>Prospective DUR- ProDUR cost avoidance for the Florida Medicaid prescription drug program is the sum of the claims that were reversed or denied and not resubmitted. The ProDUR cost avoidance for FFY 2022 was \$237,599,811. The following table summarizes the FFY 2022 data. However, cost avoidance should not be interpreted as true cost savings. While the ProDUR edit may have resulted in a claim reversal or denial, it is not known what the complete impact this has on the program. There are many prescriptions that are switched after point of sale to alternative medications, which would have an improved therapeutic benefit to the patient and would not generate a ProDUR edit. The cost of this alternative medication is not reflected in the calculation of ProDUR cost avoidance. Another factor that influenced this calculation was multiple claim submission for an individual recipient's prescription. This would result in a number of claims and ProDUR edits for one prescription. If the provider fails to reverse the various claims, the calculations would be inflated.</p> |

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 Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation, Require prior authorization (PA) |
| If "Other," please explain. | Deny claims and require a prospective drug utilization review by the pharmacist at the point of sale. |
| 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. | No |
| a. What criteria does your State use to identify candidates for lock-in (multiple responses allowed)? | N/A |
| If "Other," please explain. | N/A |
| b. Does your State have the capability to restrict the beneficiary to: | |
| i. Prescriber only | N/A |
| ii. Pharmacy only | N/A |
| iii. Prescriber and Pharmacy | N/A |
| c. What is the usual lock-in time period? | N/A |
| If "Other," please explain. | N/A |
| d. On average, what percentage of the FFS population is in lock-in status annually? | N/A |
| e. Please provide an estimate of the savings attributed to the lock-in program for the fiscal year under review. | N/A |

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

| 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 Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation, Deny claims written by this prescriber |
| If "Other," please explain. | N/A |
| 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 |
| If "Other," please explain. | Claims will deny that exceed the limits set by the Agency (i.e., Morphine Milligram Equivalent (MME), quantity limits, and day supply limits). |
| 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. | There are prescribing limits (i.e., quantity limits, duration of therapy) on non-controlled drugs based on FDA prescribing guidelines and package inserts. |
| 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. | Sections 893.055 and 893.0551, Florida Statutes does not authorize the release of PDMP information to the Agency for Health Care Administration. For cases involving Medicaid fraud, the Attorney General may request the information if the case involves prescribed controlled substances. |
| 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 |
| 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 |
| If “Other,” please explain. | N/A |
| If “Yes,” please continue. a. Has the State specified protocols for prescribers checking the PDMP? | Yes |

| Question | Response |
|--|--|
| If “Yes,” please explain. | Section 893.055, Florida Statutes and Rules 64K-1.003, Florida Administrative Code, includes guidance related to the PDMP. |
| 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? | No |
| If “No,” please explain. | A prescriber or dispenser or designee of a prescriber or dispenser who does not consult the system shall document the reason he or she did not consult the system in the patient's medical record or prescription record and shall not prescribe or dispense greater than a 3-day supply of a controlled substance to a patient. |
| 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. | Additional information is provided through a NARXCARE report, this includes risk factors, overdose risk scores, and narcotic risk scores for the prescriber and dispensers' consideration. |

| Question | Response |
|---|---|
| <p>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?</p> | <p>Yes</p> |
| <p>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).</p> | <p>Sections 893.055 and 893.0551, Florida Statutes does not authorize the release of PDMP information to the Agency for Health Care Administration.</p> |
| <p>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?</p> | <p>No</p> |
| <p>If “Yes,” please explain.</p> | <p>N/A</p> |
| <p>5. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?</p> | <p>No</p> |
| <p>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.</p> | <p>N/A</p> |

C. Opioids

| Question | Response |
|---|-----------------------------|
| <p>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?</p> | <p>Yes, for all opioids</p> |
| <p>If “No,” please explain why not.</p> | <p>N/A</p> |

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

| Question | Response |
|--|---|
| <p>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.</p> <p>a. What is the maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?</p> | 14 |
| <p>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.</p> | Other |
| <p>If “Other”, please specify.</p> | 14 |
| <p>If “No,” please explain.</p> | N/A |
| <p>2. Does your State have POS edits in place to limit the quantity dispensed of opioids?</p> | Yes |
| <p>If “No,” please explain why not.</p> | N/A |
| <p>If “Yes,” please continue.</p> | Other |
| <p>a. Does your State have POS edits in place to limit the quantity dispensed of short-acting (SA) opioids?</p> | |
| <p>If “Yes,” please specify limit as # of units.</p> | N/A |
| <p>If “No,” or “Other,” please explain.</p> | Yes, 7-day supply limit. |
| <p>b. Does your State currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?</p> | Other |
| <p>If “Yes,” please specify limit as # of units.</p> | N/A |
| <p>If “No,” or “Other,” please explain.</p> | 30-day supply limit and product specific quantity limits. |
| <p>3. Does your State have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?</p> | Yes |
| <p>If “Yes,” check all that apply.</p> | Deny claim and require PA, Require PDMP checks, Intervention letters, Requirement that prescriber has an opioid treatment plan for patients, MME daily dose program, Require diagnosis, Step therapy or clinical criteria |
| <p>If “Other,” please specify.</p> | N/A |

| Question | Response |
|---|---|
| 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. | Opioid prescribing trends and potential fraud and/or abuse are identified via automated claims review by the DUR Board. Topics reviewed include opioid claims utilization, top opioid prescriber's including specialty, top opioid recipients, Narcan/naloxone utilization, and overdose data if available. |
| If “No,” please explain why not. | N/A |
| 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 |

| Question | Response |
|---|---|
| <p>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).</p> | <p>The DUR Board voted for the hard edit to start with benzodiazepine treatment naive recipients. Treatment naive is defined by the recipient having no paid claims for a benzodiazepine in the prior 60 days. An additional 2-month soft edit is provided for benzodiazepine treatment experienced recipients with Point of Sale (POS) messaging that the third fill of concomitant therapy will deny for a prior authorization. The prior authorization is required for the benzodiazepine only. The hard edit excludes seizure, cancer, sickle cell and Long-Term Care Facility (LTCF) recipients. The hard edit only includes long-acting opiates to allow for acute treatment of pain with short acting opiates.</p> |
| <p>If “No,” please explain why not.</p> | <p>N/A</p> |
| <p>8. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and sedatives being used concurrently?</p> | <p>Yes, both POS edits and automated retrospective claim reviews</p> |
| <p>If “No,” please explain why not.</p> | <p>N/A</p> |
| <p>9. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and antipsychotics being used concurrently?</p> | <p>Yes, both POS edits and automated retrospective claim reviews</p> |
| <p>If “No,” please explain why not.</p> | <p>N/A</p> |
| <p>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?</p> | <p>Yes</p> |
| <p>If “No,” please explain why not.</p> | <p>N/A</p> |
| <p>If “Yes,” check all that apply.</p> | <p>Automated retrospective claims review</p> |
| <p>If “Automated retrospective claim reviews” and/or “Yes, provider education,” please indicate how often.</p> | <p>Quarterly</p> |
| <p>If “Other,” please specify.</p> | <p>N/A</p> |

| Question | Response |
|--|--|
| 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. | To receive an abuse deterrent opioid system requires recipients to have 2 fills of a short-acting narcotic OR a fill of any Abuse Deterrent Narcotic (ADN) within 60 days to receive an ADN. |
| If “No,” please explain. | N/A |
| 13. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency? | No |
| If “Yes,” please explain. | N/A |

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?). | For opioid treatment naive recipients, the limit is 90 MME. For treatment experienced recipients there is a soft edit at 50 MME. |
| 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 |
| 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 |

| Question | Response |
|--|--------------------------|
| b. How is the information disseminated (multiple responses allowed)? | Website, Provider notice |
| 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. | The DUR Board reviews MAT access and utilization. Prescribers initiating patients on MAT can prescribe buprenorphine sublingual tablets, buprenorphine/naloxone sublingual tablets, Suboxone film, or Zubsolv sublingual tablets via an automated prior authorization. The claim will process as paid if a recipient has a diagnosis of OUD within the past 365 days of the incoming claim. |
| If "No," please explain. | The DUR Board reviews MAT access and utilization. Prescribers initiating patients on MAT can prescribe buprenorphine sublingual tablets, buprenorphine/naloxone sublingual tablets, Suboxone film, or Zubsolv sublingual tablets via an automated prior authorization. The claim will process as paid if a recipient has a diagnosis of OUD within the past 365 days of the incoming claim. |
| 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 |
| 3. What are your limitations on the allowable length of this treatment? | No limit |
| If "Other," please explain. | N/A |

| Question | Response |
|---|---|
| 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 |
| 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. | No referral is 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. | There are limits according to FDA package inserts. |

| Question | Response |
|---|---|
| <p>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.</p> | <p>Yes</p> |
| <p>a. Does your State either manage or monitor:</p> | <p>All children</p> |
| <p>If “Other,” please explain.</p> | <p>N/A</p> |
| <p>b. Does your State have edits in place to monitor (multiple responses allowed):</p> | <p>Child's age, Dosage, Indication, Polypharmacy</p> |
| <p>Specify child’s age limit in years.</p> | <p>6</p> |
| <p>If “Other,” please explain.</p> | <p>N/A</p> |
| <p>c. Please briefly explain the specifics of your documented antipsychotic monitoring program(s).</p> | <p>The clinical pharmacist is required to review submissions for all children under six and select children over six depending on antipsychotic selection and dosage. Retrospective reviews will be performed identifying all children (including foster care) receiving antipsychotics, at least annually, by the DUR Board.</p> |
| <p>If “No,” does your State plan on implementing an antipsychotic monitoring program in the future.</p> | <p>N/A</p> |
| <p>If “Yes,” please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children.</p> | <p>N/A</p> |
| <p>If “No,” please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.</p> | <p>N/A</p> |

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. | 6 |
| If "Other," please explain. | N/A |
| c. Please briefly explain the specifics of your documented stimulant monitoring program(s). | High dose limitations are placed on all stimulants. A close prior authorization review is performed on all children less than six. |
| 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: If "Other," please explain. | All children N/A |
| b. Does your State have edits in place to monitor (multiple responses allowed): Specify child's age limit in years. If "Other," please explain. | Child's age, Dosage, Indication, Polypharmacy 6 N/A |
| c. Please briefly explain the specifics of your documented antidepressant monitoring program(s). | Quantity and age limitations are placed on antidepressants based on FDA package inserts. A close prior authorization review is performed on all children less than six. |
| 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: If "Other," please explain. | All children N/A |

| Question | Response |
|--|--|
| 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. | 6 |
| If "Other," please explain. | N/A |
| c. Please briefly explain the specifics of your documented mood stabilizer monitoring program(s). | Quantity and age limitations are placed on mood stabilizers based on FDA package inserts. A close prior authorization review is performed on all children less than six. |
| 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, Dosage, Indication, Polypharmacy |
| Specify child's age limit in years. | 6 |
| If "Other," please explain. | N/A |
| c. Please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s). | Quantity and age limitations are placed on anti-anxiety medications based on FDA package inserts. A close prior authorization review is performed on all children less than six. |
| If "No," does your State plan on implementing an antianxiety/sedative monitoring program in the future? | N/A |

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

| Question | Response |
|---|------------|
| <p>If “Yes,” please specify when you plan on implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.</p> | <p>N/A</p> |
| <p>If “No,” please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.</p> | <p>N/A</p> |

Section IX - Innovative Practices

| Question | Response |
|---|---|
| <p>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?</p> | <p>No</p> |
| <p>If “Yes,” please explain.</p> | <p>N/A</p> |
| <p>2. Summary 5 – Innovative Practices</p> <p>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).</p> | <p>The point-of-sale (POS)/prospective drug utilization review (ProDUR) system provides the Florida Agency for Health Care Administration (Agency) with the ability to meet an important objective; that is, to minimize potential drug interactions and drug-induced illness or side effects. Adverse reactions from drugs occur more frequently when a recipient visits more than one physician and/or more than one pharmacy to obtain medication. Averting adverse drug effects may result in the prevention of subsequent physician visits, hospitalizations, or additional drug therapy. Magellan Medicaid Administration has brought this technology to the Drug Utilization Review (DUR) Board which allows the Board to make recommendations for edits to address the therapeutic appropriateness of drug regimens to the Agency for implementation via the POS system. These system edits encourage providers to prescribe medications appropriately, which is the primary goal of this Board.</p> <p>The Agency continues to automate many prior authorizations. Automated prior authorizations (AutoPA's) look for information in the patient's clinical record such as ICD-10 codes or CPT codes that may be a diagnosis marker and provides the ability to systematically make a decision whether to deny or pay claims during adjudication. AutoPA's may also look for a drug or a drug combination in the patient's clinical records/drug history to pay or deny claims. In addition, AutoPA's may also include a review of submitted claims data, pharmacy information, prescriber information, number of pharmacies in a patient history or number of prescribers in history, accumulated drug days supply, accumulated dose and accumulated drug quantities.</p> |

Florida Medicaid FFS DUR FFY 2022 Individual State Annual Report

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

Section X - Managed Care Organizations (MCOs)

| Question | Response |
|--|---|
| <p>1. How many MCOs are enrolled in your State Medicaid program? If “Zero” or “None”, please skip the rest of this section.</p> | 10 |
| <p>2. Is your pharmacy program included in the capitation rate (carved in)?</p> | Partial |
| <p>If “Partial,” please check what categories of medications are carved out and handled by your FFS program (multiple responses allowed):</p> | Clotting Factors |
| <p>If “Other,” please specify the drug categories.</p> | N/A |
| <p>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?</p> | Yes, contracts are updated to address each provision |
| <p>If “Yes,” please specify effective date.</p> | 10/01/2020 |
| <p>If “No, contracts are not updated,” please explain why not.</p> | N/A |
| <p>a. Is the State complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions?</p> | Yes, state is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions |
| <p>If “Yes,” State is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions. Please explain monitoring activities.</p> | Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2020-49 sent on August 31, 2020, with the requirements of the Support Act: |
| <p>If “No,” please explain why not.</p> | 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, Same ProDUR, Same PDL |
| b. Please briefly explain your policy. | MCO plans criteria, edits, etc. cannot be more restrictive than the Agency. |
| 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 operated |
| 6. Indicate how the State oversees the FFS and MCO RetroDUR programs? Please explain oversight process. | The State oversees the DUR program which includes prospective and retrospective reviews. The State meets with the DUR Board quarterly to review drug utilization including pre and post impact analysis of edits, review of drug criteria, prior authorizations requirements, and pipeline drugs. The MCOs participate on the State DUR Board and also may operate their own internal DUR program. MCOs submit an annual report to Medicaid describing their DUR program activities. |
| 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? | MCO plans participate with the State DUR Board. The State complies with all provisions by having a DUR program that includes prospective drug review, retrospective drug review, education to providers on common drug therapy problems, and claims reviews to identify medication trends, misuse, overutilization, underutilization, therapeutic or ingredient duplications, appropriateness, medical necessity, fraud, etc. The State conducts DUR Board meetings on a quarterly basis and applies all of the above aspects in its detailed analyses and documentation and on an annual basis reports to CMS on the details and compliance of the program. MCO plan data is reviewed during the DUR meeting along with fee-for-service data. |
| 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 |
|---|---|
| <p>1. Summary 6 – Executive Summary</p> <p>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.</p> | <p>I. Drug Utilization Review Program Overview</p> <p>Magellan Medicaid Administration provides electronic claims processing and a pharmacy claims management system incorporating on-line point-of-service (POS) and prospective drug utilization review (ProDUR) for the Florida Medicaid Fee-for-Service (FFS) Program. The primary objective of the ProDUR program is to improve the quality of care for recipients by reducing the potential for drug interactions as well as adverse drug reactions. Additional goals include conserving program funds and expenditures, as well as maintaining program integrity by controlling problems of fraud and benefit abuse.</p> <p>The operation of the retrospective drug utilization review (RetroDUR) program is a shared responsibility of Magellan Medicaid Administration and the Agency for Health Care Administration (AHCA). The goal of the RetroDUR program is to promote appropriate medication prescribing by identifying patterns of potentially inappropriate prescribing or medication use. Once these patterns are reviewed and studied, potential interventions to address the issue are presented to the DUR Board for consideration. An analysis of the impact of planned interventions is created and agreed upon interventions are then communicated to physicians and/or pharmacists to improve prescribing and patient outcomes.</p> <p>II. Prospective Drug Utilization Review Program (ProDUR)</p> <p>Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation, and counseling components of pre dispensing drug therapy screening. The ProDUR system of Magellan Medicaid Administration assists the pharmacist in these functions by addressing nine different situations in which potential drug problems may exist. ProDUR is performed prior to dispensing and helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may have been previously unavailable. Because Magellan Medicaid</p> |

| Question | Response |
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| | <p>Administration's ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. ProDUR recognizes that pharmacists utilize their education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid pharmacists in their professional duties. For certain edits, as determined by the DUR Board, ProDUR edits may be overridden by the pharmacist in such cases where the pharmacist, either alone, or in consultation with prescriber has determined the accuracy and safety of the prescription. To accomplish the override, the provider must input the Reason for Service, Professional Service and Result of Service Codes in the appropriate fields. In other situations, as deemed appropriate by the DUR Board, no override of the ProDUR edit can be accomplished at the POS and a prior authorization must be obtained before the medication can be dispensed. This action adds an extra layer of safety in situations where the risks are known to be substantial, or the prescribed therapy falls outside of nationally accepted standards of care.</p> <p>Magellan Medicaid Administration's ProDUR system assists the pharmacist with the detection, evaluation, and counseling components of pre-dispensing drug therapy screening by addressing eight drug therapy problem types in which potential medication problems may exist. The screening types identified by Florida Medicaid's FFS ProDUR criteria are:</p> <ol style="list-style-type: none"> 1. Excessive Daily Dose (HD) - Alert occurs when the calculated dose per day of a drug exceeds the recommended daily dosage. The criteria for excessive daily dose are age specific. 2. Insufficient Daily Dose (LD) - Alert occurs when the calculated dose per day of a drug is less than the minimum recommended daily dosage. The criteria for insufficient daily dose are age specific. 3. Early Refill (ER) - Alert occurs when a prescription is refilled before 80 percent of the previously filled prescription's days' supply has elapsed. |

| Question | Response |
|----------|--|
| | <p>4. Therapeutic Duplication (TD) - Alert occurs when a drug that is to be dispensed is in the same therapeutic class as another drug filled within the previous six weeks.</p> <p>5. Drug-Drug Interactions (DD) - Alert occurs when a drug that is to be dispensed may interact with a previously filled drug (within the previous six weeks) from any participating pharmacy. Alerts are sent to pharmacies only on the most clinically significant drug interactions.</p> <p>6. Ingredient Duplication (ID) Alert occurs when a drug that is to be dispensed shares a common ingredient with a previously filled drug from any pharmacy.</p> <p>7. Drug-Age Contraindication (PA) - Drug-Age Contraindication alerts occur when a drug is dispensed that is not recommended for use in the age group of the patient. Age alerts can occur when the patient is too old for the given medication, is too young for the given medication, or is not within the recommended age range for this medication.</p> <p>8. Underutilization (LR) - Underutilization alerts occur when patients have waited to refill their maintenance medications beyond the specified days' supply of the previous fill.</p> <p>III. ProDUR Cost Savings</p> <p>ProDUR cost savings are calculated by tracking claims that receive ProDUR alerts to determine if the pharmacy providers dispensed these prescriptions. Cost savings are reported from the cost of claims generating an alert, which were reversed by the pharmacist and not dispensed, and on claims that denied and were not overridden.</p> <p>IV. Retrospective Drug Utilization Review (RetroDUR)</p> <p>The goal of the Florida Medicaid FFS RetroDUR Program is to promote appropriate prescribing and medication use. The RetroDUR utilization analysis, as described below, provides information that assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians and pharmacists to potential drug</p> |

| Question | Response |
|----------|---|
| | <p>therapy problems, identifies opportunities to improve drug therapy, and makes recommendations to avoid drug therapy problems.</p> <p>The operation of the retrospective drug utilization review (RetroDUR) program is a shared responsibility of Magellan Medicaid Administration and the Agency for Health Care Administration. The RetroDUR program examines patterns of drug therapy utilization to detect potentially inappropriate prescribing or to examine prescribing patterns that are outside the established standard of care based on national guidelines or accepted standards of practice. The RetroDUR review process emphasizes medication classes where there is high utilization and/or high risk associated with those classes of medications. Recent updates to standards of practice, in the form of published peer-reviewed guidelines, as well as important safety communications from the US Food and Drug Administration (FDA) service are utilized to ensure timely reviews of important therapeutic issues affecting Florida Medicaid FFS recipients. Utilizing pharmacy claims history, medical claims history and diagnostic information captured on medical claims, Magellan Medicaid Administration can provide a robust analysis of utilization and identify areas of concern. These analyses are presented to the DUR Board quarterly, along with background information and details of currently accepted medical guidelines, to help guide recommendations for specific interventions or edits that may be appropriate to implement based on the RetroDUR findings. Impact analyses are performed regarding specific recommendations and the DUR Board is informed prior to the implementation of any such edits. A follow-up post edit implementation analysis is performed after a specified time interval and these results are presented to the DUR Board as well to ensure the intended outcomes of the edit are being met and resulting in improved quality of care for Florida Medicaid FFS recipients. Depending on the clinical situation, communication to prescribers and/or pharmacies may be accomplished through posting a provider alert on the Agency website. Specific drug classes that will be reviewed at upcoming quarterly Pharmacy & Therapeutics (P & T) meetings are examined for recommendations by the DUR Board to serve the state collaboratively along with the members of the P & T committee. In this capacity, the</p> |

| Question | Response |
|----------|---|
| | <p>DUR Board serves to provide advisory input to the P & T committee based on drug utilization patterns that are examined and reviewed as part of the RetroDUR process.</p> <p>RetroDUR Cost Analysis</p> <p>The provision of high-quality drug therapy not only results in improved patient health but may also result in program cost savings. It is important to quantify the effect of interventions on the cost of drug therapy. Magellan Medicaid Administration performs a post-edit implementation analysis for all RetroDUR interventions. This analysis examines any changes in number of claims, number of recipients or potential cost savings that may have occurred because of the intervention.</p> <p>Cost savings may vary due to a variety of factors including the class of medication, the intervention selected, the lag time before the recipient's next physician visit when changes in drug therapy may occur or changing patient demographics. Some interventions based on RetroDUR review emphasize the need to increase spending on a particular class of medications to improve adherence. Improved adherence for many classes of medications has been shown to improve outcomes and lessen other, long-term medical expenditures.</p> <p>Post implementation analyses of RetroDUR initiatives in FFY 2022 demonstrated cost savings as documented below: The Lyrica automated prior authorization produced a \$13,527.48 savings. The long-acting opiate and benzodiazepine concomitant therapy soft edit produced a \$103.92 savings.</p> |