FFY 2016 Medicaid Drug Utilization Review Annual Report

Response ID:28; ryPDVDHGx5YS5vMrj Data

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1. I. DEMOGRAPHIC INFORMATION

I-1. State Name Abbreviation

NY

2. I-2. MEDICAID AGENCY INFORMATION

Identify State person responsible for DUR Annual Report preparation.

I-2-1. Name

John F. Naioti, Jr., R.Ph.

3. I-2-2. Email Address:

John.Naioti@health.NY.gov

4. I-2-3. Area Code/Phone Number (number only, no hyphen, example 4107860000)

5184863209

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5. II. PROSPECTIVE DUR (ProDUR)

II-1. Indicate the type of your pharmacy POS vendor – (Contractor, State-operated, Other).

Contractor

6. If contractor or other, please identify the vendor name or explain.

CSRA

7. II-2. If not State-operated, is the POS vendor also the MMIS Fiscal agent?

Yes

8. II-3. Identify prospective DUR criteria source.

First Data Bank

If answer to II-3 above is "Other," please specify here.

9. II-4. Are new prospective DUR criteria approved by the DUR Board?

Yes

If answer to II-4 above is "No," please explain.

10. II-5. When the pharmacist receives a Pro DUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "conflict, intervention and outcome" codes?

Yes

11. II-6. How often do you receive and review periodic reports providing individual pharmacy provider activity in summary and in detail?

Quarterly

a) If the answer to II-6 above is "Never," please explain why you do not receive and review the reports.

12. b) If you receive reports, do you follow-up with those providers who routinely override with interventions?

No

c) If the answer to (b) above is "Yes," by what method do you follow-up?

d) If the answer to (c) above is "Other," please explain.

13. If the answer to (b) above is "No," please explain why you do not follow-up with providers.

Program activity that appears to have a high level of overrides is evaluated through a clinical review of utilization and system edits by the DUR board and a potential upgrade/modification of ProDUR edits, RetroDUR edits or both.

14. II-7. Early Refill:

a) At what percent threshold do you set your system to edit?

	Percentage
Non-controlled drugs:	75%
Controlled drugs:	75%

15. b) When an early refill message occurs, does the State require prior authorization for non-controlled drugs?

Yes

16. If answer to (b) above is "Yes," who obtains authorization?

Prescriber

If answer to (b) above is "No," can the pharmacist override at the point of service?

17. c) When an early refill message occurs, does the State require prior authorization for controlled drugs?

Yes

18. If answer to (c) above is "Yes," who obtains authorization?

Prescriber

If answer to (c) above is "No," can the pharmacist override at the point of service?

19. II-8. 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:

	Select
a) Lost/stolen Rx	No
b) Vacation	No
c) Other	No

20. If answer to II-8 above is " Other," please provide details.

21. II-9. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?

Yes

22. a) If answer to II-9 above is "Yes," please explain your edit.

The enhanced edit denies a claim if more than a 10-day supply of medication is remaining of the cumulative amount that has been dispensed over the previous 90 days, and will augment current editing where claims are denied when less than 75% of the previously dispensed amount has been used (the more stringent rule will apply). Members may, with prescriber intervention, have the ability to refill their prescription(s) early through the process of prior authorization, allowing for ample supply of their medication(s) on hand.

b) If answer to II-9 above is "No," do you plan to implement this edit?

23. II-10. Does the state or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS?

Yes

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24. II-11. Has the state provided DUR data requested on Table 1 – Top 10 Drug Claims Data reviewed by the DUR Board?

Yes

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25. TABLE 1 – TOP DRUG CLAIMS DATA REVIEWED BY THE DUR BOARD

List the requested data in each category in the chart below.
Column 1- Top 10 Prior Authorization (PA) Requests by Drug Name
Column 2- Top 10 PA Requests by Drug Class
Column 3- Top 5 Claim Denial Reasons other than eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, Age Edits)
Column 4- Top 10 Drug Names by Amount Paid
Column 5- From Data in column 4, Determine the Percentage of Total Drug Spend
Column 6- Top 10 Drug Names by Claim Count
Column 7- From Data in Column 6, Determine the Percentage of Total Claims

	Top 10 PA Requests By Drug Name	Top 10 PA Requests By Drug Class	Top 5 Claim Denial Reasons (i.e. QL, Early Refill, PA, Duplication)	Top 10 Drug Names by Amount Paid	% of Total Spent for Drugs by Amount Paid	Top 10 Drug Names by Claim Count	Drugs By Claim Count % of Total Claims
1	OMEPRAZOLE	ATARACTICS-TRANQUILIZERS	Early Refill	HARVONI	3.53%	METFORMIN HCL	0.96%
2	QUETIAPINE FUMARATE	NARCOTIC ANALGESICS	Drug Drug Interaction	ABILIFY	2.29%	AMLODIPINE BESYLATE	0.89%
3	OXYCODONE HCL	ANTI-ULCER PREPS/GASTROINTESTINAL PREPS	High Dose Alert	TRUVADA	2.01%	ATORVASTATIN CALCIUM	0.88%
4	CLONAZEPAM	ANTICONVULSANTS	Drug Disease Precaution	LANTUS	1.95%	GABAPENTIN LISINOPRIL	0.84%
5	OXYCODONE-ACETAMINOPHEN	PSYCHOSTIMULANTS-ANTIDEPRESSANTS	Therapeutic Duplication	ADVATE	1.65%	LISINOPRIL LEVOTHYROXINE SODIUM	0.82%
6	RISPERIDONE	AMPHETAMINE PREPARATIONS		VIEKIRA PAK	1.53%	LEVOTHYROXINE SODIUM	0.81%
7	ZOLPIDEM TARTRATE	CNS STIMULANTS		ARIPIPRAZOLE	1.51%	RISPERIDONE	0.80%
8	HYDROCODONE-ACETAMINOPHEN	ANTIVIRALS		NOVOLOG	1.22%	DIVALPROEX SODIUM	0.75%
9	ALPRAZOLAM	SEDATIVE NON-BARBITURATE		PREZISTA	1.10%	SIMVASTATIN	0.71%
10	ADDERALL XR	OTHER ANTIHYPERTENSIVES		SOVALDI	1.07%	SERTRALINE HCL	0.62%

26. II-12. Section 1927(g)(A) of the Social Security 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? Check all that apply.

b) State Board of Pharmacy
c) Other- please explain

27. If answer to II-12 above is "Other," please explain.

On site pharmacy inspections performed by Office of Professional Discipline.

28. II-13. Has the state included Attachment 1 – Pharmacy Oral Counseling Compliance Report, a report on state efforts to monitor pharmacy compliance with the oral counseling requirement?

Yes

29. ATTACHMENT 1 - PHARMACY ORAL COUNSELING COMPLIANCE REPORT

This attachment reports the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid agency, the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the Omnibus Budget Reduction Act (OBRA) of 1990 prospective DUR requirement. This report details State efforts to monitor pharmacy compliance with the oral counseling requirement. This attachment should describe in detail the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported. State ATT#-FFY-State Abbrev-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) ATT1-2016-AZ-POCCR

ATT1-2016-NY-POCCR.docx

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30. III. RETROSPECTIVE DUR (RetroDUR)

III-1. Identify, by name and type, the vendor that performed your retrospective DUR activities during the time period covered by this report. (company, academic institution or other organization)

Other organization

31. Organization Name

Health Information Designs, LLC (company) and State University of NY at Buffalo (academic)

32. III-1. a) Is the retrospective DUR vendor also the Medicaid fiscal agent?

No

33. III-1. b) Is this retrospective DUR vendor also the developer/supplier of your retrospective DUR Criteria?

Yes

If answer to III-1 (b) above is "No," please explain.

34. III-2. Does the DUR Board approve the retrospective DUR criteria?

Yes

If answer to III-2 above is "No," please explain.

35. III-3. Has the state included Attachment 2 - Retrospective DUR Educational Outreach Summary, a year end summary of the Top 10 problem types for which educational interventions were taken?

Yes

36. ATTACHMENT 2 – RETROSPECTIVE EDUCATIONAL OUTREACH SUMMARY This is a year-end summary report on RetroDUR screening and educational interventions. The year-end summary reports should be limited to the TOP 10 problem with the largest number of exceptions. The results of RetroDUR screening and interventions should be included. State ATT#-FFY-State Abbrev-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) ATT2-2016-AZ-REOS

ATT2-2016-NY-REOS.xlsx

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37. IV. DUR BOARD ACTIVITY

IV-1. State is including a summary report of DUR Board activities and meeting minutes during the time period covered by this report as Attachment 3 - Summary of DUR Board Activities.

Yes

38.
ATTACHMENT 3 - SUMMARY OF DUR BOARD ACTIVITES

This summary should be a brief descriptive report on DUR Board activities during the fiscal year reported. This summary should:

*** Indicate the number of DUR Board meetings held.**
*** List additions/deletions to DUR Board approved criteria.**
a. For prospective DUR, list problem type/drug combinations added or deleted.
b. For retrospective DUR, list therapeutic categories added or deleted.

*** 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.**

*** 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). ATT#-FFY-State Abbrev-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) ATT3-2016-AZ-SDBA**

ATT3-2016-NY-SDBA.docx

39. IV-2. Does your State have a Disease Management Program?

Yes

40. If answer to IV-2 above is "Yes," have you performed an analysis of the program's effectiveness?

No

If "Yes," please provide a brief summary of your findings.

41. If answer to IV-2 above is "Yes," is your DUR Board involved with this program?

No

42. IV-3. Does your State have an approved CMS Medication Therapy Management Program?

No

If "Yes," to IV-3 above, have you performed an analysis of the program's effectiveness?

If "Yes," please provide a brief summary of your findings.

If answer to IV-3 above is "Yes," is your DUR Board involved with this program?

43. If answer to IV-3 above is "No," are you planning to develop and implement a program?

No

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44. V. PHYSICIAN ADMINISTERED DRUGS

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

V-1. Prospective DUR?

Yes

If "No" to V-1 above, do you have a plan to include this information in your DUR criteria in the future?

45. V-2. Retrospective DUR?

No

46. If "No" to V-2 above, do you have a plan to include this information in your DUR criteria in the future?

No

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47. VI. GENERIC POLICY AND UTILIZATION DATA

VI-1. State is including a description of policies used that may affect generic utilization percentage as Attachment 4 - Generic Drug Substitution Policies.

Yes

48. ATTACHMENT 4 – GENERIC DRUG SUBSTITUTION POLICIES
Please report any factors that could affect your generic utilization percentage and include any relevant documentation. ATT#-FFY-State Abbrev-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) ATT4-2016-AZ-GDSP

ATT4-2016-NY-GDSP.docx

49. VI-2. In addition to the requirement that the prescriber write in his/her 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

50. If "Yes" to VI-2 above, check all that apply.

d) Other – please explain

51. If Other, please explain.

On April 26, 2010, New York Medicaid implemented a cost containment initiative which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent.

52. To answer questions VI-3 and VI-4 below use TABLE 2 – GENERIC UTILIZATION DATA

Please provide the following utilization data for this DUR reporting period for all covered outpatient drugs paid. Exclude Third Party Liability.
(COMPLETE TABLE2)

Computation Instructions:

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 ÷ (S + N + I) × 100 = Generic Utilization Percentage

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

$N ÷ ($S + $N + $I) × 100 = 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 (see Key below), which can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Drug-Utilization-Review.html (Click on the link "an NDC and Drug Category file [ZIP]," then open the Medicaid Drug Product File 4th Qtr 2016 Excel file). This file will be made available from CMS to facilitate consistent reporting across States with this data request.

KEY:
Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market.
Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market.
Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity.

	Single-Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I)Drugs
Total Number of Claims	700,987	6,094,380	448,430
Total Reimbursement Amount Less Co-Pay	103,089,027	121,951,288	48,973,476

53. VI-3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in Table 2 - Generic Drug Utilization Data.

Number of Generic Claims

6094380

54. Total Number of claims

7243797

55. Generic Utilization Percentage

84%

56. VI-4. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period using the computation instructions in Table 2 – Generic Drug Utilization Data.

Generic Dollars

121951288

57. Total Dollars

274013791

58. Generic Expenditure Percentage

45%

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59. VII. PROGRAM EVALUATION/COST SAVINGS/COST AVOIDANCE

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

Yes

60. VII-2. Who conducted your program evaluation for the cost savings estimate/cost avoidance? (company, academic institution, other institution)

Other institution

61. Organization Name to VII-2

NYS Dept. of Health evaluates ProDUR and Health Information Designs, LLC evaluates RetroDUR.

62. VII-3. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below.

	Data
ProDUR Total Estimated Avoided Costs	$53,249,436
RetroDUR Total Estimated Avoided Costs	$4,454,705
Other cost avoidance	0
Grand Total estimated Avoided Costs	$57,704,141

63. VII-4. Please provide the estimated percent impact of your state's cost savings/cost avoidance program compared to total drug expenditures for covered outpatient drugs.

Use the following formula:

Divide the estimated Grand Total Estimated Avoided Costs from Question 3 above by the total dollar amount provided in Section VI, Question 4. Then mutiply this number by 100.

Grand Estimated Net Savings Amount / Total Dollar Amount * 100 =

21%

64. VII-5. State is providing the Medicaid Cost Savings/Cost Avoidance Evaluation as Attachment 5 – Cost Savings/Cost Avoidance Methodology.

Yes

65. ATTACHMENT 5 - COST SAVINGS/COST AVOIDANCE METHODOLOGY Include copies of Cost Savings/Cost Avoidance evaluation prepared by State or its contractor noting the methodology used. ATT#--FFY-State Abbrev-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) ATT5-2016-AZ-CSCAM

ATT5-2016-NY-CSCAM.docx

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66. VIII. FRAUD, WASTE AND ABUSE DETECTION

VIII A. LOCK-IN or PATIENT REVIEW AND RESTRICTIVE PROGRAMS

VIII-A1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries?

Yes

67. If "Yes" to VIII-A1 above, what action(s) does this process initiate? Check all that apply.

d. Other (eg.SURS,Office of Inspector General), please explain.

68. If (d) "Other," above is selected, please explain.

Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation. OMIG administers the lock-in program.

69. VIII-A2. Do you have to a "lock-in" program for beneficiaries who misuse or abuse controlled substances?

Yes

70. If answer to VIII-A2 above is "Yes," what criteria does your state use to identify candidates for lock-in? Check all that apply.

Number of controlled substances (CS)
Different prescribers of CS
Multiple pharmacies
Number days' supply of CS
Exclusivity of short-acting opioids
Multiple ER visits

71. If answer to VIII-A2 above is "Yes" do you restrict the beneficiary to:

Both prescriber and pharmacy

72. If answer to VIII-A2 above is "Yes," what is the usual "lock-in" time period?

Other

73. If answer to above is "Other," please explain.

Two years of lock-in for the first offense. Thereafter, for a continuation (due to continued abuse or overuse while restriction/lock-in still in place) or re-restriction/lock-in, the second term would be three years, and the third time or more would be six years.

74. VIII-A3. On the average, what percentage of the FFS population is in lock-in status annually?

0.25%

75. VIII-A4. Please provide an estimate of the savings attributed to the lock-in program for the fiscal year under review.

5000000

76. VIII-A5. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers?

Yes

77. If answer to VIII-A5 above is "Yes," what actions does this process initiate? Check all that apply.

d. ____ Other - please explain:

78. If (d) "Other" above is selected, please explain.

Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.

79. VIII-A6. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by pharmacy providers?

Yes

80. If answer to VIII-A6 above is "Yes," what actions does this process initiate? Check all that apply.

d. ____ Other - please explain:

81. If (d) "Other" above is selected, please explain.

Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.

82. VIII-A7. Do you have a documented process in place that identifies potential fraud or abuse of non-controlled drugs by beneficiaries?

Yes

83. If answer to VIII-A7 above is "Yes," please explain your program for fraud or abuse of non-controlled substances.

Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation. OMIG administers the lock-in program.

84.

VIII B. PRESCRPTION DRUG MONITORING PROGRAM (PDMP)

VIII-B1. Does your state have a Prescription Drug Monitoring Program (PDMP)?

Yes

85. If answer to VIII-B1 above is "Yes," does your agency have the ability to query the state's PDMP database?

No

86. If answer to VIII-B1 above is "Yes," do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing restricted substances?

Yes

87. If answer to VIII-B1 above is "Yes," please explain how the state applies this information to control fraud and abuse.

In NYS, all prescribers writing a prescription for a Schedule II-IV controlled substance have a mandatory duty to consult the Prescription Monitoring Program Registry, with limited exceptions. The mandatory duty to consult the PDMP provision affords practitioners with current, patient-specific controlled substance prescription information intended to inform the practitioner of controlled substance utilization by their patient at the point of prescribing.As of June 14, 2016, New York State practitioners and pharmacists (if allowed under the participating state's data sharing agreement) have access to New Jersey, Connecticut, Massachusetts, Rhode Island, New Hampshire and Vermont's PMP data. NYS is working with Pennsylvania to share data once they are able. NYS is also sharing PDMP information with other states including Virginia, West Virginia, South Carolina, Minnesota, Indiana and the District of Columbia.

88. If answer to VIII-B1 above is "Yes," do you also have access to border states' PDMP information?

Yes

89. VIII-B2. Are there barriers that hinder the agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?

No

If answer to VIII-B2 above is "Yes," please explain the barriers (eg. lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).

90. VIII-B3. Have you had any changes to your state's Prescription Drug Monitoring Program during this reporting period that have improved the agency's ability to access PDMP data?

No

If answer to VIII-B3 above is "Yes," please explain.

91. VIII C. Pain Management Controls

VIII-C1. Does your state or your agency require that Pain Management providers be certified?

No

92. VIII-C2. Does your program obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?

No

If answer to VIII-C2 above is "Yes," do you apply this DEA file to your ProDur POS edits to prevent unauthorized prescribing?

If answer above is "Yes," please explain how the information is applied.

93. If answer to VIII-C2 above is "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

No

94. VIII-C3. Do you apply this DEA file to your RetroDUR reviews?

No

If answer to VIII-C3 above is "Yes," please explain how it is applied.

95. VIII-C4. Do you have measures in place to either monitor or manage the prescribing of methadone for pain management?

Yes

96. If answer to VIII-C4 above is "Yes," please check all that apply.

quantity limits
step therapy or clinical criteria

If answer to VIII-C4 above is either "No" or "Other," 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 methadone for pain management.

97. VIII D. OPIOIDS

VIII-D1. Do you currently have POS edits in place to limit the quantity of short-acting opioids?

Yes

98. a) If answer to VIII-D1 above is "Yes," what is your maximum daily limit in terms of numbers of units (i.e. tablets, capsules)?

Please indicate the number of unit(s) per day.

Edits for Opioids – Short-Acting-Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease-Initial prescription for opioid-naïve patients limited to a 15-day supply-Exception for diagnosis of cancer or sickle cell PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy-PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy-----STEP THERAPY (ST)-Nucynta® (tapentadol IR) – Trial with tramadol and one (1) preferred opioid before tapentadol immediate-release (IR)---FREQUENCY/QUANTITY/DURATION (F/Q/D)---Quantity Limits: Nucynta® (tapentadol IR):Maximum 6 (six) units per day; 180 units per 30 days-Nucynta® (tapentadol IR):Maximum daily dose of tapentadol IR and tapentadol ER formulations used in combination not to exceed 500mg/day- Morphine and congeners immediate-release (IR) non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone):Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days-Xartemis® XR (oxycodone/acetaminophen):Maximum 4 (four) units per day, 120 (one hundred twenty) units per 30 (thirty) days----Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis---Morphine and congeners immediate-release (IR) combination products maximum recommended: acetaminophen (4 grams),aspirin (4 grams),ibuprofen (3.2 grams),or the FDA approved maximum opioid dosage as listed in the PI, whichever is less---Duration Limits:90 days for patients without a diagnosis of cancer or sickle-cell disease.

99. b) If answer to VIII-D1 above is "Yes," what is your maximum days supply per prescription limitation?

other, please explain

100. If answer to (b) above is "Other," please explain.

• 90 day supply limit
• Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease

CLINICAL CRITERIA (CC)
• For opioid: Naïve patients - limited to a 15 days supply for all initial opioid prescriptions, except for patients with diagnosis of sickle cell disease or cancer
• Medical necessity rationale for opioid therapy is required for patients on established buprenorphine opioid dependence therapy
• PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy

101. VIII-D2. Do you currently have POS edits in place to limit the quantity of long-acting opioids?

Yes

102. a) If answer to VIII-D2 above is "Yes," what is your maximum daily limit in terms of numbers of units (i.e. tablets, capsules)?

3 units/day

103. b) If answer to VIII-D2 above is "Yes," what is your maximum days supply per prescription limitation?

other, please explain

104. If answer to (b) above is "Other," please explain.

• 90 day supply
• Hydromorphone ER, oxymorphone ER- Maximum 4 (four) units per day, 120 units per 30 days
• Morphine ER (MS Contin 100mg only) - Maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days
• All other long acting opioids are either 2 or 3 times a day.

105. VIII-D3. Do you currently have edits in place to monitor opioids and benzodiazepines being used concurrently?

Yes

106. If answer to VIII-D3 above is "Yes," please explain.

PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy

107. VIII E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

VIII-E1. Have you set recommended maximum morphine equivalent daily dose measures?

No

If answer to VIII-E1 above is "Yes," what is your maximum morphine equivalent daily dose limit in milligrams?

mg per day

108. If answer to VIII-E1 above is "No," please explain the measure or program you utilize.

The NYS DURB has recommended quantity/ frequency/ duration limits to promote the safe and clinically effective use of opioids in the New York State Medicaid Program. The process examines FDA recommended dosages and considers equivalent MED levels. The combined efforts of the Medicaid Prescriber Education Program (MPEP), the Drug Information Response Center (DIRC) and Retrospective Drug Utilization Review (RetroDUR) program promotes the clinical effectiveness and medical appropriateness of opioid utilization by way of point-of-sale (POS) prospective edits, RetroDUR evaluations and the application of educational interventions for prescribers and pharmacists. In addition, on March 27, 2016 New York State began mandatory e-prescribing controlled substances.

109. VIII-E2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage?

No

If answer to VIII-E2 above is "Yes," how is the information disseminated?

If answer to above is "Other," please explain.

110. VIII-E3. Do you have an algorithm in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been

exceeded?

No

111. VIII F. BUPRENORPHINE and BUPRENORPHINE/NALOXONE COMBINATIONS

VIII-F1. Does your agency set total mg/ day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

Yes

112. If answer to VIII-F1 above is "Yes," please specify the total mg/day?

24mg

If answer to above is "Other," please explain.

113. VIII-F2. What are your limitations on the allowable length of this treatment?

no limit

If "Other," please explain.

114. VIII-F3. Do you require that the maximum mg per day allowable be reduced after a set period of time?

No

a) If answer to VIII-F3 above is "Yes," what is your reduced (maintenance) dosage?

If answer to (a) above is "Other," please explain.

b) If answer to VIII-F3 above is "Yes," what are your limitations on the allowable length of reduced dosage treatment?

If answer to (b) above is "Other," please explain.

115. VIII-F4. Do you have at least one preferred buprenorphine/naloxone combination product available on your PDL?

Yes

116. VIII-F5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug?

Yes

117. If answer to VIII-F5 above is "Yes," can the POS pharmacist override the edit?

No

118. VIII G. ANTIPSYCHOTICS /STIMULANTS

VIII G1. ANTIPSYCHOTICS

VIII-G1-1. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?

Yes

119. a) If answer to VIII-G1-1 above is "Yes," do you either manage or monitor:

all children

If answer to (a) above is other, please explain

120. b) If answer to VIII-G1-1 above is "Yes," do you have edits in place to monitor? Check all that apply.

Child's Age
Dosage

121. c) Please briefly explain the specifics of your antipsychotic monitoring program(s).

• DUR Board recommended drug-specific minimum age parameters have been established. (Automatic bypass for established therapy.)
• Fee for service diagnosis parameters for second-generation antipsychotics in the pediatric population.
• Diagnosis requirement for the initial prescription for patients between minimum age (as defined by the DURB for the FFS population) and 18 years of age. (Automatic bypass for established therapy.)

122. d) If you do not have antipsychotic monitoring program, do you plan on implementing a program in the future?

Yes

If answer to (d) above is "No," please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

123. VIII-G2. STIMULANTS

VIII-G2-1 Do you have any documented restrictions or special program in place to monitor, manage or control the use of stimulants?

Yes

124. a) If answer to VIII-G2-1 above is "Yes," is your program limited to :

both

125. b) Please briefly explain your program.

Quantity limits for patients less than 18 years of age to include:
• Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration)
• Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg not to exceed 2 units daily.

Quantity limits for patients 18 years of age and older to include:
• Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 30 days
• Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 30 days. Concerta 36mg not to exceed 2 units daily.
• For patients 18 years of age and older: a 90 day supply may be obtained with confirmation of FDA approved, Compendia supported or Medicaid covered diagnosis

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126.
IX. INNOVATIVE PRACTICES

Have you developed any innovative practices during the past year which you have included in Attachment 6 - Innovative Practices (e.g. Hepatitis C, Cystic Fibrosis, MEDD, Value Based Purchasing)?

Yes

127. Attachment 6 - Innovative Practices
Please describe in detailed narrative form 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. (e.g. disease management, academic detailing, automated pre-authorizations, continuing education programs). ATT#-FFY-State Abbrev-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) ATT6-2016-AZ-IPN

ATT6-2016-NY-IPN.docx

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128. X. E-PRESCRIBING

X-1. Does your MMIS or pharmacy vendor have a portal to electronically provide, patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing, upon inquiry?

No

a) If answer to X-1 above is "Yes," do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

b) If 'Yes', please explain the evaluation methodology in Attachment 7 – E-Prescribing Activity Summary. Please describe all development and implementation plans/accomplishments in the area of e-prescribing. Include any evaluation of the effectiveness of this technology (e.g. number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings). ATT7-FFY-State Abbrev-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) ATT7-2016-AZ-EAS

129. c) If answer to X-1 above is "No," are you planning to develop this capability?

No

130. X-2. Does your system use the NCPDP Origin Code that indicates the prescription source?

Yes

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131. XI. MANAGED CARE ORGANIZATIONS (MCOs)

XI-1. Does your state have MCOs?

Yes

132.
XI-2. Is your pharmacy program included in the capitation rate (carved-in)?

Yes

If answer to XI-2 above is "partial," please specify the drug-categories that are carved out.

133. XI-3. Does the state set requirements for the MCO's pharmacy benefit? (e.g. same PDL, same ProDUR/Retro DUR)?

Yes

134. If answer to XI-3 above is "Yes," please check all requirements that apply below.

Formulary Reviews

135. If answer to XI-3 above is "Yes," please briefly explain your policy.

Plans establish their own formularies and prior authorization processes. Plan formularies must include all categories of prescription drugs on the NYS Medicaid fee-for-service list of reimbursable drugs.

If answer to XI-3 above is "No," do you plan to set standard in the future?

136. XI-4. Does the state require the MCOs to report their DUR activities?

No

a) If answer to XI-4 above is "Yes," please explain your review process.

137. b) If answer to XI-4 above is "No,", do you plan to develop a program to have MCOs report their DUR activities in the future?

Yes

c) If answer to (b) above is "No," please explain.

138. XI-5. Does all of the Medicaid MCOs in your state have a targeted intervention program (i.e. CMC/ Lock In) for the misuse or abuse of controlled substances?

No

139. If answer to XI-5 above is "No," please explain.

In New York, the Office of the Medicaid Inspector General (OMIG) is the organizational component dedicated to anti-fraud and abuse activities. The OMIG is an independent entity within the New York State Department of Health. New York has implemented a rigorous lock-in program for beneficiaries with a demonstrated pattern of abusive utilization of Medicaid services. These primary providers may include a primary medical provider, pharmacy, hospital, durable medical equipment provider, dentist, and podiatrist. In addition, restricted beneficiaries who are eligible for managed care are transitioned into managed care. The MCOs also have their own restriction programs, which are monitored by OMIG.

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140. XII. EXECUTIVE SUMMARY - Attachment 8 – Executive Summary

ATT8-FFY-State Abbrev-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) ATT8-2016-AZ-ES

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