BRIAN SANDOVAL
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
1100 E. William Street, Suite 101
Carson City, Nevada 89701
(775) 684-3600

Richard Whitley
Interim Director

LAURIE SQUARTSOFF
Administrator

NOTICE OF PUBLIC MEETING – DRUG USE REVIEW BOARD

AGENDA

Date of Posting: **xxxxx**

Date of Meeting: **Thursday, September 3, 2015 at 5:30 PM**

Name of Organization: **The State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP), Drug Use Review Board (DUR).**

Place of Meeting: **Best Western Plus Airport Plaza Hotel**
1981 Terminal Way
Reno, NV 89502
Phone: (775) 348-6370

AGENDA

1. **Call to Order and Roll Call**

2. **Public Comment on Any Matter on the Agenda**

3. **Administrative**

   a. **For Possible Action:** Review and Approve Meeting Minutes from April 23, 2015.

   b. Status Update by DHCFP
      i. Public Comment
      ii. Update on ICD-10.

   c. Review submitted Annual DUR Report submitted to CMS

4. **Board Action**

   a. **For Possible Action**: Discussion on Psychotropics for Children and Adolescents prior authorization criteria and prior authorization form

i. Public comment on the prior proposed criteria and prior authorization process and policy
ii. Discussion by the Board and review of utilization data and current policy
iii. Possible adoption of prior authorization criteria, policy and prior authorization form

b. **For Possible Action**: Discussion on Lock-in Program proposed changes to criteria

i. Public comment on the Lock-in Program criteria process and policy
ii. Discussion by the Board and review of utilization data, current policy and the Pharmacy Lock-In Referral to Therapy
iii. Possible adoption of updated Lock-in policy and criteria

5. Clinical Presentations

a. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for Ivacaftor (Kalydeco®)

i. Public comment on adoption of policy.
ii. Presentation of utilization and clinical information.
iii. Discussion by the Board and review of utilization data.
iv. Possible adoption of prior authorization criteria/policy.

b. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for medications for the treatment of onychomycosis

i. Public comment on proposed clinical prior authorization criteria.
ii. Presentation of utilization and clinical information.
iii. Discussion by the Board and review of utilization data.
iv. Proposed adoption of updated prior authorization criteria.

c. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for sedative/hypnotic medications.

i. Public Comment on proposed clinical prior authorization criteria.
ii. Presentation of utilization and clinical information.
iii. Discussion by the Board and review of utilization data.
iv. Proposed adoption of updated prior authorization criteria

d. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for Ivabradine (Corlanor®)

i. Public comment on proposed clinical prior authorization criteria.
ii. Presentation of utilization and clinical information.
iii. Discussion by Board and review of utilization data.
iv. Proposed adoption of updated prior authorization criteria.

6. Public Comment on any DUR Board Requested Report

7. DUR Board Requested Reports

a. Report on diabetic patient compliance for blood glucose monitoring receiving insulin

i. Discussion by the Board and review of utilization data.

8. Public Comment on any Standard DUR Report

9. Standard DUR Reports

b. Review of Prescribing/Program Trends.

i. Top 10 Therapeutic Classes for Q4 2014, Q1 2015, and Q2 2015 (by Payment and by Claims).
ii. Top 50 Drugs of Q4 2014, Q1 2015, and Q2 2015 (by Payment and by Claims).

c. Concurrent Drug Utilization Review (ProDUR)

i. Review of Q4 2014, Q1 2015 and Q2 2015.
ii. Review of Top Encounters by Problem Type.

d. Retrospective Drug Utilization Review (RetroDUR)

i. Status of previous quarter.
ii. Status of current quarter.
iii. Review and discussion of responses.

8. Closing Discussion

a. Public comments on any subject.

b. Date and location of the next meeting.

i. Discussion of the time of the next meeting.

c. Adjournment.

Nevada Medicaid is unaware of any financial impact to other entities or local government due to this public hearing, other than as stated above.

PLEASE NOTE: Items may be taken out of order at the discretion of the chairperson.

Items may be combined for consideration by the public body. Items may be pulled or removed from the agenda at any time. If an action item is not completed within the time frame that has been allotted, that action item will be continued at a future time designated and announced at this meeting by the chairperson. All public comment may be limited to 5 minutes.

This notice and agenda have been posted at www.dhcfp.nv.gov and http://notice.nv.gov

Notice of this meeting and draft copies of the changes will be available on or after the date of this notice at the DHCFP Web site www.dhcfp.nv.gov, Carson City Central office and Las Vegas DHCFP. The agenda posting of this meeting can be viewed at the following locations: Nevada State Library; Carson City Library; Churchill County Library; Las Vegas Library; Douglas County Library; Elko County Library; Lincoln County Library; Lyon County Library; Mineral County Library; Tonopah Public Library; Pershing County Library; Goldfield Public Library; Eureka Branch Library; Humboldt County Library; Lander County Library; Storey County Library; Washoe County Library; and White Pine County Library and may be reviewed during normal business hours.

If requested in writing, a copy of the meeting materials will be mailed to you. Requests and/or written comments may be sent to Rita Mackie at the Division of Health Care Financing and Policy, 1100 E. William Street, Suite 101, Carson City, NV 89701, at least 3 days before the public hearing.

All persons that have requested in writing to receive the Public Hearings agenda have been duly notified by mail or e-mail.

Note: We are pleased to make reasonable accommodations for members of the public who are physically challenged and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Division of Health Care Financing and Policy, in writing, at 1100 East William Street, Suite 101, Carson City, Nevada 89701 or call Rita Mackie at (775) 684-3681, as soon as possible, or e-mail at rmackie@dhcfp.nv.gov

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Nevada Medicaid
Drug Use Review (DUR) Board
Draft Meeting Minutes

The Division of Health Care Financing and Policy (DHCFP) Drug Use Review (DUR) Board conducted a public meeting on April 23, 2015 beginning at 5:30 pm at the following location:

Best Western Plus Airport Plaza Hotel
1981 Terminal Way
Reno, NV 89502
Phone: (775) 348-6370

Board Members Present:
Paul Oesterman, Pharm.D., Chairman; Dave England, Pharm.D.; James Marx, M.D; Chris Shea, Pharm.D., Michael Owens, MD

Others Present:
DHCFP:
Coleen Lawrence, Chief, Program Services; Mary Griffith, RN, Pharmacy Services Specialist; Darrell Faircloth, Senior Deputy Attorney General;

HPES:
Beth Slamowitz, Pharm.D.

Catamaran:
Carl Jeffery, Pharm.D. Account Manager

Others Present:
Philip Malinas, MD; Gerado Rodriguez, MD; Jeanette Belz, NV Psychiatric Assn.; Larry Nussbaum, MD; Joe Haas, PhD; Ryan Ley, MD; Perry Olshan, Ademes; Jon Bloomfield, Jazz Pharm; Chris Holtzer, Abbvie; Lovell Robinson, Abbvie; Amy Khan, McKesson/HCGP; Rama Karina, Abbvie; Pauline Whelan, Alkermes; Ann Nelson, Vertex; Gregg Gittus, Alkermes; Matt Larsen, UNSOM; Shane Hall, Purdue; Sal Fofaso, Horizon; Karen Nishihara, Alkermes; Brandon Snaffe, Celgene; Melissa Walsh, Novartis; Tom O'Connor, Novartis; Kathrine Thomas, UNSOM; Erika Ryst, MD, UNSOM; Natalie Jaymes, Child Neurology; Jen Stanton, Zogenix; Errol Gould, Zogenix; Jill Gardner, Jazz; Robin Wat, Zogenix

1. Call to Order and Roll Call

Carl Jeffery, Catamaran
James Marx
Dave England
Paul Oesterman
Darryl Faircloth, Deputy Attorney General
Chris Shea
Mary Griffith, DHCFP
Coleen Lawrence, DHCFP

2. Review / Approval of Meeting Minutes:

One change requested of prior meeting minutes. There is a statement that forensic pathologists perform 1,000 forensic autopsies a year in Las Vegas. The correction is that EACH pathologist performs 1,000 forensic autopsies a year. That winds up closer to 8,000 – 9,000 for Las Vegas for the year. The reasoning behind that statement is that the National Academy of Forensic Pathologists recommends that no more than 250 forensic autopsies be done a year per pathologist and in Las Vegas they are doing 1,000. This was on page 4, halfway down. The upshot of doing so many forensic autopsies a year is that the pathologist really doesn't have enough time to do a thorough forensic examination because they are doing four times as many autopsies as they should be. As a result, some of the deaths that are written off as opioid overdoses may be something else. No other changes.

JM - Move for Approval
DE - Seconded.
Voted Ayes Across the Board
Motion Approved

3. Public Comment on Any Matter on the Agenda

None

4. Administrative

a. Status Update by DHCFP – Coleen Lawrence, Chief, Program Services - Specifically spoke about the legislative session. From our last meeting, we have two bills that are specific to Pharmacy. SB422 - Pharmacy and Therapeutic committee with our PDL. It doesn't really impact the DUR Board. Changes have been made to the original writing of the bill, a friendly amendment was added. The sunset language has been amended that we will now have an extension of the sunset language for an additional two years. Now the sunset language will be extended until 2017. What that means is that we will continue to operate our PDL as we do today for an additional two years.

   For SB14, a Division bill, recommends and requests that the membership of the Pharmacy and Therapeutic Committee be modified. For the Pharmacy and Therapeutic Committee to meet the law, the way that the membership was written, we were having difficulty filling the Pharmacy and Therapeutic Committee because we had to be at 50% and at less than at 50% we had a requirement of having so many members and not to exceed an amount of membership. If you do the mathematical equation, we were really having a hard time meeting the recruitment requirements. There was a point in time when were not able to hold two Pharmacy and Therapeutic Committees back to back and that was because we were having a

hard time filling some membership slots. With this bill, the minimum and maximum membership requirements were changed and the 50% rule will keep the same intent of the makeup of the pharmacists vs. physicians, it just doesn't put us into the mathematical equation that makes it nearly impossible for us to recruit pharmacists vs. physicians. Literally it made it near impossible for recruitment for the Governor's office.

Both bills have passed their first house. We are pretty positive that they will pass their second house.

5. Presentation and Discussion of Nevada's Health Care Guidance Program

a. Dr. Amy Khan, MD, MPH, Medical Director, Nevada Health Care Guidance Program, McKesson Care Management - Nevada Health Care Guidance Program is relatively new. Pharmacists are a key part of our team when it comes to the health care team. The spirit of the Health Care Guidance Program is really about collaboration and supporting integrative care in the service of our patients. I'm an internist by training, also an addiction medicine physician with a background in public health and preventive medicine.

I want to talk about goals, who is eligible for the program, and then opportunities to drive better health outcomes, quality of care, and clinical effectiveness for those who are benefiting from these services.

This is a program that launched in June of 2014. It's supported through a CMS grant waiver program, a research and demonstration project. I work for McKesson and we subcontract with Value Options. We provide the services for this program. It's a Care Management Organization, also known as a CMO and not to be confused with an MCO or Managed Care Organization. We serve the FFS Medicaid population among those who are qualified.

Our goals for the program are simple: We are going to improve the quality of care for the members who are participating in the program through letting providers know about care gaps, care improvement opportunities, driving good quality care through the adoption and provision of clinical quality services. We do track numerous quality measures as well as assure others provide good quality care for those being served and ultimately to drive better health outcomes. Most, not all, of those in our program have a chronic condition. The exception being pregnancy. We want to assure that mom is healthy throughout that pregnancy and all those who have those chronic illnesses, we're driving their optimal health outcomes, which isn't always the case in health care. We want to do that through assuring "Right Place, Right Time, Right Dose" if you will and I use that term broadly along with "Right Location, Right Provider" and ultimately improve the patient experience in the process so that these individuals are not only aware of what their issues are, but feel confident in being able to adopt practices, lifestyle changes, adhere to medication compliance, or other types of treatments that drive better health outcomes. Ultimately this is about recognizing we have a finite amount of resources. We need to not only use them preciously, judiciously if you will, but ultimately this is about optimizing the value of what we spend in health care.

We are absolutely committed to, at the very least, cost neutrality by providing this additional level of benefit. We're certainly not going to spend any more money, but through the addition

of care coordination, redirecting people away from places like emergency departments for their primary care, or avoiding ambulatory sensitive hospitalizations, we're going to be able to improve costs as well.

Who is eligible to participate? It's important to, and I know you probably have been tracking this, is the landscape today within Medicaid. We have roughly 600K recipients in Medicaid in Nevada. The majority are enrolled in Managed Care, or that MCO because our geographic distribution is such that you either live in urban Clark, or urban Washoe. 30% of Medicaid is in the FFS product. Our program serves those medically complex, chronically ill individuals who have one or more selected conditions that are permitted within the waiver. That really boils down to roughly one out of four of that 30% of Medicaid are enrolled in this program. The figures that I've provided and the slide (presented during the meeting) are based on March data. There has been a bump in the enrollment due to redeterminations. It's still roughly a 70/30 split. Our program can enroll up to 41,500 qualifying individuals, but we are excluded from enrolling those who are receiving other types of aid.

(Page 3 of handout presenting during meeting) I've listed for you those chronic conditions. These are the usual suspects. Listed is diabetes, heart disease, COPD, asthma, obesity, as well as chronic HIV/AIDS, as well as oncology conditions, chronic kidney disease, end stage renal disease, and a host of issues including musculoskeletal disorders, as well as many behavioral health issues - substance abuse disorders, primary psychiatric diagnosis, and a number of other conditions. Again, we enroll those eligible and qualifying FFS Medicaid recipients, including children and adults. We are precluded from enrolling those in certain categories which you see in the shaded box - The dual eligible, those who are the Medicare/Medicaid folks are not eligible for our program, nor are those who are receiving services in other programs, like those who are recipients in other waiver programs, those who are receiving targeted case management services from selective providers for certain behavioral health issues, or active in the Juvenile Justice System, active in the foster care system, etc.

Questions about who we enroll in this program?

Question: Why is there a 41,500 limit?

Answer: That is the cap that CMS put on the research and demonstration waiver. Essentially we are going to demonstrate that compared to the before, after we've made a difference in this. Depending upon how the growth of Medicaid proceeds, we may find that there may be a waiting list.

Question: So this is for a proof of concept?

Answer: Yes. What's important is that we all think about what's working in our health care delivery system today and what's not. And this demonstrates a real need that we know is the bridge between that patient and the provider, so we can essentially extend the care of that provider, so that it's much more clinically effective for the person for whom it's intended. That's what is important when we think about our opportunities to improve care models, via team based models, and also work in terms of continuation and coordination of care.

Our program supports clinical effectiveness in a number of ways. First, our administrative office is conveniently located right next to the Business Lines Unit in Carson City, right next to the Division of Healthcare and Financing and Policy. We have a local leadership team, all from Nevada, the majority does reside in northern Nevada, although our Clinical Operations Lead is in southern Nevada. Our staff is geographically distributed across the state in the communities where the majority of our recipients who are enrolled in the program live, work, and get their care. The staff is diverse with clinical registered nurses with various certifications and experience with disease management, risk case management, maternity management, oncology management, as well as licensed clinical social workers and other counselors who are licensed. We have a few non-licensed staff, community health workers, as well as peer specialists. As you can imagine, the subset of the individuals we serve are very mobile. They do not have a steady domicile. Folks do not necessarily map to an address, or a phone number. Our team will actually go out on the streets and look for people in all sorts of places with the intent to develop a relationship, develop a connection, and to really bring people into the fold. It's really quite broad in terms of the dimensions that we serve, or provide support to these individuals.

If you look at the top of page 4 (hand out provided in meeting) this is the delivery model. None of this is unique in and of itself. Everybody is standing on a platform. In the center is the patient. The most important entity next to the patient is their family member, their neighbor, their partner, those who are most familiar with the patient who may be providing housing, who might be providing food security, who might be offering support to take people to appointments, or in terms of just social connections and social support. Surrounding that individual would be that primary provider, whether that's a behavioral health provider, primary care provider, etc. On the right of this picture is that primary care nurse / community based primary nurse. That's really what I would say our care management staff would be. That could be a social worker, a community health worker, but behind is all the folks involved in the care of the individual and it's really important that people are connected to each other, that the right and left arm know what's happening because ultimately this is to serve the patient. What we have today and historically is that we don't always have the ability to work together. Essentially what I see in the back with the social workers, the community health educators, maybe folks within a hospital system, or extended care system, Pharmacists, are others who are meeting the needs, or helping to address that care plan that the patient understands, can embrace, can deploy, has the confidence to follow through with, and we'll support the individual.

We work very hard with the provider and the recipient to make sure there is transparency with what the provider has intended and what the patient who is going to be deploying that treatment plan is actually doing. There are 3 kinds of areas / primary components of the program that are listed on the bottom of page 4. Those are the services that enrollees get. We review the eligible population on a monthly basis, assess them based on claims, demographics, and other data including utilization management data from our partners at HP. Basically we look at and assess a different level of risk. Identifying those who are most impactable and deploying resources as appropriate in terms of the intensity of the Care Management services. We focus on care coordination, transitions of care coming from one side of service to another

(from a hospital, to a skilled facility, to a rehab facility, to a home health situation, to home, or living with a neighbor or a family member)

We also work with the myriad of providers who might be local, or not. We know that many of constituents live in rural Nevada and they are not getting their specialty services there. So how do they get to their appointment in Las Vegas, or maybe they are being referred to the University of Utah. How are we working with them to insure that they are getting to their appointments? We work with individuals around education, skills training, assess their ability and their competency, and assess literacy and take a broad, 360, holistic approach to assessing those dimensions. Working directly with providers, we will identify care gaps, opportunities for improvement. When we do talk with individuals and confirm a care plan, we share that information with the primary treating provider, so that if there needs to be adjustments, or additional considerations, we will note that and review that with the individual. Providers are encouraged, as are other stakeholders who serve this population, to refer patients to us to bring up new issues in a timely manner, or to provide referrals for those who aren't in our program who would be eligible to join. We have a 24/7 nurse advice line that our recipients are eligible to use. We promote that use for those particularly who may not know where to go for care with an emphasis of redirecting people to the appropriate place of service. For many folks, their primary home for care was the emergency department, so we really do understand how important it is for folks to have the right information given that kind of feedback based on their symptoms, based on their condition. This is an informed nurse advice line. This isn't a call where we didn't know anything about the patient.

I want to share with you some of the outcomes of the findings since our launch in June. At the top of page 5, what you'll see here is a bar chart looking at the distribution by age group and noting male vs. female. About half of our recipients are under the age of twenty.

There are slightly more males than females. As you look in the over 20 age group, we see that the distribution is a little bit different. There are more representations of women. It drops down when you get into that 60+ age group because as you know and heard earlier, the Medicare/Medicaid folks are not eligible for this patient program. We looked at those who are enrolled based on one or more of the qualifying conditions and then looked at what was the most prevalent diagnosis that we got on claims of those enrollees. The bar chart on the bottom of that page shows that roughly half of the diagnoses were behavioral health (psychiatric diagnosis, substance abuse diagnosis) The other half were chronic medical conditions. I think it's important to talk about the opportunity to serve this group and all Nevadans when it comes to addressing behavioral health needs.

We assessed among the enrolled population, those top 10 gaps in care. When you look at the top 10, 3/10 relate to individuals getting the recommended preventative screening for cancer. That would be mammography, pap smears, and colorectal cancer screening for those that are recommended. For example, colorectal cancer screening is now recommended for those aged 50 years and older. Those came up as the three of the top 10. The next 3 have to do with the management of chronic disease, in this case, diabetes and heart disease. This would be the use of aspirin in those with no contra indication for diabetes and those with cardiac artery disease. And then 4 out of the 10 relate to pinning this access and availability to behavioral health

services and the ability of primary care to manage behavioral health conditions and in this example, what came up was bipolar and depression. What we saw was medication compliance for both antidepressant therapy and patient treatment for bipolar disorder were among the top 10.

What I've included to share with you tonight were some selected quality measures. These are certainly similar to HEDIS, but these were just a spot measure. We weren't able to do the precise HEDIS measure for this particular presentation, but basically I'm sharing with you the proportion of those enrolled recipients that would meet that particular recommendation. In this case, 75% of those who had asthma, had access to their medication. Another case, beta blocker use after acute MI. 41% of recipients in the program had achieved that particular measure.

Question: On the identified conditions, the second identified condition is hypertension and then in the slide you show that the second lowest proportion made meeting ideal is hypertension, yet it's not in your 10 identified gaps.

Answer: The gaps in care were those top identified gaps. The people had hypertension, but it wasn't a gap in care necessarily. It didn't make the top ten gaps in care.

Question: How do you define a gap in care?

Answer: A gap in care would be, for example, it's recommended that you have colorectal cancer screening because you're over 50, but you didn't get it. You haven't had it within the period of time it would be appropriate. So if you were hypertensive, the gap in care that would have made the top 10, would be if you weren't on antihypertensives, or you hadn't been looking at the gap, you hadn't gotten a refill.

Question: How could hypertension only be 38% met and yet it wasn't one of your gaps? I don't understand that.

Answer: This particular measure was multidrug therapy, including a thiazide diuretic. 38% of people with hypertension, in this particular group, had been on multidrug therapy including a thiazide diuretic. 38% of that particular group. It wasn't among the top 10 gaps across all of the population.

Moving on to the top of slide seven, there is a highlighted need in Nevada for behavioral health care. There is a need for access and availability for psychiatric care. For these particular measures the slide shows that we are having a tough time with timely follow ups after hospitalization, or mental health conditions. 0.2% of those who are discharged with a mental health disorder where seen within 7 days. 0.6% within 30 days. What relates to that is are we able to make sure that those individuals get on the proper medications and are monitored on the medications and have their medications refilled in a timely manner, or are taking them as appropriate? We absolutely support these individuals. Many times our psychiatric nurses or social workers, their relationship is really therapeutic with these folks, but we're not the provider. Getting that person to a provider is something we are working hard to do.

Stakeholder involvement, provider involvement is really key to the success of this program. We want to work closely with the treating community. We really have to think about a team based approach. The pharmacist provides education, nurses, MAs, community health workers, all sorts of people helping to support the individual, but we've got to do it in a coordinated, collaborative way.

We're interested in ideas and thoughts to help us achieve our goals.

Top of page 8 - A screen shot of the eligibility verification system/method to readily identify those who have been identified for enrollment in this program. It would be listed as first, FFS Medicaid, and then the very next line would be CMO Care Management. The moniker we use is the Health Care Guidance Program. Seeing the CMO Care Management label, it might be an opportunity for the pharmacist to reinforce to that patient the tools available to them as part of the program.

Our real-time referral form is available on the DHCFP website under the CMO Care Management Organization tab.

Question/Statement: I think one way that the Board could possibly partner with the Health Care Guidance Program is that the Board is always looking for opportunities to look with the retro profile letters and with the medication compliance. I think that would probably be a really good opportunity. We could talk with Dr. Khan offline further about looking at the compliance letters and we could look at how we could feed that information over and that might be a good referral opportunity.

Statement: Just like how we identify Lock-Ins.

Statement: Exactly. Except it would be medication compliance.

Question: Out of the 41,500 that you can enroll in this program, how many do you currently have enrolled?

Answer: We saw about 39,500 in the fall of last year, however, with the redeterminations process, we've had some flux that peaked and then came down in the new year. In the past month we've seen an additional lowering due to pulling deactive case management folks. We're at roughly 35,800 now. Hoping to expand this because we believe there is real value in helping people, particularly in this category of Medicaid recipients who are FFS and have chronic conditions. There's a long list of conditions in which you're eligible to participate. For many of these folks it's numerous conditions that they are managing.

Question: This is funded by CMS for 5 years. What happens in 5 years and CMS dries up?

Answer: We need to demonstrate things that work. This will show value. What we have to learn from it is how is this going to become part of the new paradigm of health care? We're in the midst of a new statewide innovation planning model, we have opportunities for reform. Recent changes in congress related to fixing SGR, so it's catalyzing some opportunities to be

more accountable around outcomes and collaboration and integration of services. I can't tell you exactly what is going to happen at the end of 5 years, but I will tell you this is a great opportunity to demonstrate innovation and collaboration to drive true clinical effectiveness.

Question: How is the program publicized to providers because I wasn't aware of it at all and I think it's a great program? Unfortunately if you really promoted it now, you only have a very small window of opportunity for maybe 5,000 patients. There could be a deluge if you really start promoting it.

Answer: We've been very actively promoting it. All participating Medicaid providers were mailed a Provider handbook. We've mailed them every six months. In addition to that we link the patient back to the physician. We start with the high volume practices and move down.

Statement: You might be better to send postcards, pamphlets, flyers, because doctors aren't going to read handbooks.

Answer: Noted. We are going to start a quarterly newsletter that will be faxed. We have many advertisements in many primary care educational conferences, Nevada health conferences, Medicaid conferences, blurbs in newsletters in other organizations.

Statement: I believe one of the challenges has been having the FFS plans and then the MCO plans. Honestly the FFS doesn't have a marketing budget. We depend on the vendor who comes in and a lot of associations vs. having the value added with the Managed Care plans is they literally have departments around marketing. That is one of the issues.

Question: What does this program do in regards to specialist care? As a physician, I can't get patients in to see specialists. Is there anything in this program that would help me identify providers who might be enrolled?

Answer: We have limited access and availability. Some areas are harder than others. What we will do is work with you, your patient, identify who would accept the Medicaid patient into the practice. We assure that patient gets to that appointment. If the patient gets appointed with a specialist, one way we know we can help particularly with the next patient you have, is make sure that patient keeps their appointments. If they have a specialty appointment that takes 2 months to get in and they don't show, the appetite for that specialist to book a Medicaid patient is not very good. We work very hard to make sure people get to their appointment. We look across the field where we can find a specialist and it's a challenge. We together are going to have to talk about what our opportunities are with specialty care.

There are many communities doing all sorts of creative things about that including econsultations, to prioritize a consult, this way the sickest patients will have some priority to get in and be seen so that they are not harmed by waiting. A less complicated patient that might be able to be managed with less collaboration could then get into that next available slot. These are ways, if we work together, between the patient, provider, the specialist, the hospital, or the other services that the patient needs, but this is where we'll all have to come to the table and work together.

Question: Sitting on various medical staff across rural Nevada, psychiatry is one of the number one issues that those physicians struggle with. They have a patient that is comes in and it's either fly them out to Reno from Hawthorne, and 9 times out of 10, the patient comes in and they have absolutely no support, so I guess, I'm assuming you have reached out to those providers because they are out there trying to provide primary care in a clinic for a sore throat and then they run across the hallway to try to deal with an ER patient, walk down the hallway to deal with a long term care patient, and they have absolutely no support. It's getting better with econsults, but there's really nothing for psychiatry.

Answer: We know behavioral health is a big challenge. A good portion of our staff is behavioral health trained. To a certain extent that relationship can be therapeutic. We work very hard with the psychiatrists in the state. There are not many of them who will accept Medicaid patients. We are educating primary care to feel more comfortable in managing some of the non-complicated, basic psychiatric diagnoses. Many folks who trained in primary care didn't have formal psychiatric training. How to screen and treat substance related disorders, or other types of psychiatric disorders. That may or may not have been part of training. So to the extent that we can partner, we work with them at health centers, other Federally Qualified Health Clinics. We're on the docket with the project Echo group to get didactic education, some case examples. We arming the physicians out in the rural fields who have to be primary care and the specialist with the education that they need to be able to treat some of the simpler cases. Excited about the efforts around telemedicine. There continues to be some debate in the legislative session right now. It's a Medicaid covered service but we don't have a lot of people taking advantage of it right now. Also, to what extent are we helping our future doctors to be able to address the needs that we have here in Nevada and how do we work with the educators and trainers to really help develop the kinds of expertise that we need, not just for physicians, but for mid-level providers or nurse practitioners, PAs, etc.

Question: Do you have the ability to provide this educational support?

Answer: We do. Dr. Ley has a multi-level educational program looking at common psychiatric conditions, management of substance abuse issues, recognition and treatment of delirium and psychotic disorders and has offered that up to clinics. That is why, with project Echo, we can be more efficient with getting out to many more providers. I've been in contact with Dr. Class, who is over project Echo, as recent as a couple of days ago to confirm that the Health Care Guidance Program is involved. There has been one class on diabetes and what the role of care management is. Many physicians don't know what care management is.

We know there is an area for education on what is care management, what is care coordination, what's case management, what's utilization management. We want people to know about the 24 hour nurse line so that they are not running to the emergency department inappropriately, or accessing a service when they could have called a few days before. When to call to doctor, for example. Arming these individuals with a kind of confidence, knowledge, and ability to utilize the health care system appropriately.

Statement: I think the practitioners at Hawthorne would really like to hear about your

program.

Response: We have been down to the medical facility a couple of times and would love the opportunity to meet with the clinicians as well.

Dr. Ley - Value Options Medical Director, Psychiatrist: Anytime, I can come out to Hawthorne to present, if you wanted to talk about depression and how to manage it, or what to do if someone comes in who is cutting, or self-harm, dually hospitalized, anything like that.

Response: I'll bring it up with medical staff next week and make sure that they are aware.

Comment: We don't have any problems with referral of worker's comp patients. The bottom line is, if you have adequate reimbursement you'll find that there are plenty of providers available. We really have this system where we have very good reimbursement and readily available consultations and we have a very parsimonious system where we have a hard time actually coercing providers to even serve in that system, so I think that somewhere in between you have to be able to bring that reimbursement level up. There has been a recent survey of healthiest states and if you look at the healthiest states, those states all have the highest instance of physician reimbursement. We really have to get these objectives in alignment because you can't have both.

Response: There are efforts in the budget to request increasing reimbursement, but I would submit that in addition to the reimbursement issue is collaborative care. Even with reimbursement adjusted we have to have people working together for the individual. How do we work together to serve our neighbors, our community? We're talking about nearly one out of 4 or one out of 5 people are covered under Medicaid.

6. Clinical Presentations

a. **For Possible Action:** Discussion on Psychotropics for Children and Adolescents prior authorization process and policy.
   i. Public comment on the prior authorization process and policy.
   Dr. Matt Larson - Child Psychiatry Fellowship Program - Concerning the new PA policy.
   I assume it was implemented to decrease the polypharmacy and to decrease the overuse of psychotropics in children. I spoke last week to about 100 doctors telling them to watch out for bias and off label use and spoke about the subject myself. At the same time, I fear that the patient harm greatly outweighs the patient benefit, as I've already seen in my own patients in the last three weeks.

   First, I have a 12-year-old with impulse control disorder that I can't put on Depakote because I can't get it approved with a citation of why it should be approved for him. It's been rejected and I'm telling his mother he will either have to be in juvenile detention, or residential treatment because he's going to be kicked out of school and beat people up and that is where he's headed.

Next, I have a 3-year-old who was born on heroin and was in the NICU for 2 months and never developed because he couldn't sleep. We went through melatonin and other medications. Now we're up to Trazodone and I think, how would I ever, with the new policy, get a 3-year-old on Trazodone? No one is going to approve that. There is no evidence for it. There's no peer review literature because there isn't much for heroin addicted children who can't sleep and don't develop because of it.

The patient this week is a 15-year-old autistic hemophiliac who is severely aggressive, who has been stabilized with risperidone, but has gained 4 pounds a month and has been for the last 7 months. He's now getting gynecomastia. I'm worried about diabetes, metabolic syndrome. I tried to change him over to Geodon, however Geodon is not approved for aggression related to autism. I cited literature from the American Academy of Child and Adolescent Psychiatrists, their practice parameters. It was rejected and now I'm forced to tell the family, "You can either pay cash (about $160 per month), we can keep him on risperidone and fight diabetes, or we can take him off and you can have an aggressive child." And that is kind of where I'm stuck.

As Dr. Khan pointed out, there is severe shortage of Medicaid providers for child psychiatry in the state. My fear is that this further limits our time to see patients. When I saw the letter of medical necessity, I asked myself "What is a prescription from a child psychiatrist, if not a letter of medical necessity?" I don't do cosmetic psychiatry. I prescribe anything that I don't see as medically necessary. When I write prescriptions, it is medically necessary for that child. Then I get the PA back already from the previous policy, where I state Yes I've seen them, yes I've seen them regularly, yes they need this, I'm not doing polypharmacy, it's for its own indication, trying to detail exactly why it's medically necessary and now there's an additional letter required. All I can see is that we are trying to decrease access to care for our patients. If the current policy stands, my question would be, I've received two letters so far asking that my medications have been denied and I'm asked to attend hearings. Do you want me spending my time writing letters and attending hearings, to get my patients the best evidence based medicine, or do you want me seeing more patients, but I'm not able to use the best medicine available because my hands are tied because it won't be paid for? That is my concern and that is my worry with the new policy as I've already seen it in the last 3 weeks affect multiple patients. This is someone in child psychiatry. I don't know what's happening with neurology, family practice, pediatrics, across the state. Thank you.

Carl Jeffery Catamaran: You must have some sort of training that says using Trazodone in a 3-year-old is safe and effective.

Larson: Yes.

Jeffery: Is that something you can share with the call center? I'm just wondering where that came from.

Larson: There is no peer reviewed literature using Trazodone in infants and toddlers that I could find. The only one I found was a study of 8 kids who had severe neurological disorder and it worked to help them sleep and in my note before this came out, I cited that because I'm already scared. I'm using Trazodone in a 3-year-old. I want a little bit of evidence so that in case someone goes back and looks in my charts to see that I looked this up and tried to find what I could. My concern is if I can't even get Depakote for an impulse control disorder teenager, how would I ever get this approved with the new policy. So I have a lot of training, but as far as peer reviewed literature that's required and a letter of medical necessity even citing it, I'm afraid it will be denied.

Coleen Lawrence: I want to clarify. This is not a new policy. It has always been in Chapter 1200 of the Medicaid Services Manual. The policy states that Nevada Medicaid is not allowed to pay for off label medication unless it's peer reviewed or found in the compendia. That's why Carl is trying to find, do you have any literature to support it?

Larson: Yes.

Lawrence: So it's not new policy that we implemented. All we were asking for now is on the form, because if you were to call in and you were to have that peer discussion with the call center, they should be asking you "What was your source for this prescription, for your background to write this prescription?" This was not a change in policy. The change in the process was that letter of medical necessity for the 0-5-year-olds. Yes that absolutely was a change. We did not create it. We did not envision this as a brand new one, we did steal it from a couple of states. The actual policy has been in Chapter 1200 for all drugs. It's not just for psychotropic medications for children. So that's why Dr. Jeffery was asking "Do you have any of the background information for this?" I'm pretty sure that people who have been in this room with me plenty of times have heard our DUR Board talk about this.

Larson: It must be new application of the policy because until 3 weeks ago, everything was approved when I made those phone calls and I'm told on the phone, "We can't do this as a phone call. This cannot be approved over the phone. You must send in the documentation." I send it in with the practice parameters stating that I can use the medications and it's still denied. So if it's not new policy, then it's being applied in new ways.

Lawrence: You did cite the information then?

Larson: Yes. I wrote the citation.

Lawrence: That's one thing we need to look at. If you wrote the citation, absolutely because that's one thing we want to do. We are not trying to make this a punitive measure by any means. But we are trying to make it an appropriate application of these medications and so one thing that we've talked about is putting on our website

the FDA indications for one. That was in the web announcement. We will collect all of the citations together and we will put them out there as other states have done because, I'm sure you're an absolutely outstanding prescriber, but I always have a bad apple out there. And we want to educate that bad apple and we want to make sure that they are appropriately using appropriate prescribing patterns. We want to use this as an education opportunity and I want to make sure that my clinical call center is on the same page that you are.

Larson: I assumed that was the purpose, but my fear is ultimate consequences. That this is extended much, much further than you expected and it is harming far more than it is benefiting. But there will be a benefit because you will stop the bad apples and you will stop a slew of good. That's my fear. It's already happening.

DE: Evidence based and peer reviewed literature and what's on the net are pretty open. The discussions that we had through the first round of all of this. Our main concern was, going by the book, or going by what the FDA says are two different things. Because what the FDA approves is what the manufacture wants approved and that's what makes the most money. If there are studies going on out there that shows what a drug has been used for and there are peer reviews on that, that is one of the reasons we put a lot of the information into the process because knowing the FDA guidelines isn't enough to treat everything. There's always other things out there that are good but they just haven't had the emphasis put on them by the manufacturer. And that is why we specifically went after looking at peer reviewed journals to give you options. Even though you may have a small case study, but at the same time, if there is something out there, whether it is from Australia, Asia, Africa, wherever that shows that this might help, let's give it a try. But at the same time, we can't fund experimental therapies, but at the same time, maybe with some of these patients you might want to contact some of the pharmaceutical industries and say "We might meet an issue here." and you could go after orphan drug status, if they are that unique.

But we specifically put a lot of options into the process so that you could have access to things rather than just restricting it to what the FDA says.

Larson: I don't believe the policy is being implemented the way you intended it. I'm already using these peer reviewed articles. I'm already doing those things and they're still being rejected. I'm not given a chance to resubmit. They say come to a hearing.

Board: Then we have some process issues we need to take a look at.

Response Larson: That is my concern. There are severe process issues and I want it addressed.

JM: From a prescriber's standpoint, I would be a little uncomfortable proposing a dose that I know is neither safe, efficacious, nor possibly even therapeutic or maybe

toxic, based upon a study of 8 patients. The other hat I wear is as a malpractice insurer and I would be on very, very thin ice defending a doctor who proposed something like that on the basis of that sort of information. I think that if you're not even a little bit uncomfortable prescribing something like that, I would wonder why. I prescribe off label all of the time, but I feel that I have better foundation, better ground for doing what I do. Obviously you deal with some very challenging situations and we all appreciate that, but we have policies in place that are directed toward the middle of the road and not the outliers. I would be very uncomfortable proposing therapy like you are on the basis of such thinly investigated dosing. Especially in a 3-year-old. The dosing regimen can be very, very different due to a lot of brain issues, but I would be very uncomfortable in your situation.

Larson: And I would hope everyone is. Isn't that the purpose of a subspecialist? To identify mechanisms and medicines for these kids? Because I don't see the kids that go to family practice and pediatrics.

JM: You're dealing with people. I think you have to be really aware of what you are doing.

Larson: Right. That's why I have attending physicians checking to make sure they agree.

JM: If they're willing to go to court for you, that would be good because that's the world we live in. I have to defend doctors all of the time for doing very, very appropriate things.

Larson: And I hope the same. If patients are being harmed everyone is willing to go to court for them. For those who are not getting the medications they need.

JM: You're probably on safer grounds not doing something that's recognized than doing something that is sort of out there.

Larson: There's no harm, but I'm afraid we're doing the opposite.

JM: Exactly. I appreciate that.

Geraldo Rodriguez: Pediatric Neurologist - I second what Dr. Larson just said. He's referring to patients who are covered under the guidelines of what we are discussing. So children under 5 being treated with medications that are being used off label. Pediatric psychiatry and pediatric neurology are off label. We have essentially no FDA approved medications. That's just the way it is. Using Seroquel in a 3-year-old, we do it. We have little printed data, but there is plenty for anecdotal and training data, and sometime we cannot convey that in a complete scenario. I want to share with you the plight of the patients with epilepsy. Many patients with epilepsy are treated with emergency first aid seizure medications that are to be used for an emergency at the discretion of the family and myself. This is to

avoid having to call the ambulance and go to the emergency room. One of the medications that are accepted nationwide as standard of care is , or Ativan. It is in the textbooks, but it is not an FDA approved use to use for epilepsy, but in emergency rooms, in intensive care units, across the country on our patients, it is used widely and successfully. It saves lives and it saves resources. Since three weeks ago, with the new implementation of the old policy, we have had numerous patients have their not filled. The message they get from the pharmacy, or what I hear from the parents is, the pharmacies said the medication was not approved for insurance, or the pharmacy didn't fill my medication, or you (me) must have done something wrong because my prescription wasn't ready. But most of those patients will not purchase the agent. They will just go without and then we hear about it when they land in the emergency room. So some of our patients have had seizures and have had to use the emergency medical services. I want to give you an example of a couple of kids who have been on for over a year. One is a near drowning victim. He is on a home respirator, a home feeding tube, has epilepsy, is on various other agents, and he has been receiving for over a year. Whatever implementation with the pharmacy that was taking place allowed him to have this medication and allowed me to prescribe it. Now it was denied. Between patients, in my lunch hour, I got on the phone after it was denied, and I spoke with a very nice young man who happens to be in Massachusetts. I was trying to explain to him what was going on. I asked him what was his degree. He said he had no degree, he was a pharmacy tech. So I asked him what he does. He said he gathers information to approve or deny these requests. After a little bit, he offered for me to talk to the pharmacist. Sometime later I was able to talk to the pharmacist, explained the issue. He understood and agreed completely, but he said "You're in the state of Nevada and the state of Nevada needs a letter of medical necessity." I asked him what it should say and he offered some ideas. He said we need peer review literature. We did provide that and the medication was approved sometime later, the next couple of days. But that took some time. The other patient, on the same day, another baby with epilepsy. This one has hydrocephalus, a shunt, hemorrhage at birth, an intensive care nursery survivor, cerebral palsy, a very sick little baby. His , which had been prescribed and filled for over a year, was denied. So we have the same situation, but now I'm catching on to this. I updated the documentation with the help of a prior authorization specialist. We also received approval for that medication. But we have heard of several patients where we were not notified or the parents did not advocate. They fell through the cracks. The medication was not filled and they went without it. Most of my patients with epilepsy have a prescription for lorazepam. Since I learned to use it, I minimized their morbility and utilization. I'm not going to do this for every patient. I don't have time. The guy in Massachusetts said, "Why don't you put him on diazepam?" Diazepam has an FDA indication. And it kind of does and it doesn't quite work as well, so I may use diazepam and they may have to dose up a little more frequently. It may work, but it won't work as well. This is one example of a medication that is not esoteric. It is used nationwide. It is the standard of care, but we're hitting roadblocks. Not every family and every patient can negotiate these roadblocks. I hear from other providers who don't have the will, or the time or the assistance, or don't have someone like a prior

authorization specialist to help. So they just tell the parents "Sorry, your insurance doesn't cover this medication." And in pediatric neurology, in the Medicaid population, that means this kid is not going to get his medication because those families are unlikely to pay for this medication out of pocket.

PO: Coleen, just a quick question. Part of this PA process, was it to include anti-epileptic drugs?

Lawrence: We were just reading the policy. We found a hole in our existing policy because neurology actually bypasses this entire process.

Jeffery: There's a contradiction in the policy. I was emailed about your specific case. On one side we've got Chapter 1200 that says if you're a pediatric neurologist and you're writing for anticonvulsants for a seizure disorder, then you are exempt from the policy. But in another part of the chapter it says we can only approve it for FDA approved indications, or somewhere it's listed as common compendia. We're going to have to get that clarified.

Rodriguez: I appreciate the language, but in pediatric neurology, many of the agents that we use are not approved under 18, or under 12, or under 5, or under 4. By the time you're under 3, you pretty much have access to only herbal medications.

Lawrence: Let me answer your question in 2 different parts. For the treatment for seizure disorders, we do have the piece of the policy that reads that the following diagnosis begins with and we talk about epilepsy. We had it for anticonvulsants and for the provider specialty code, for neurology / pediatric neurology. If you wrote those diagnoses on the claim, we bypassed that. That's been in our policy for years. That's why we were trying to read over here to see why you were even hitting the system for that drug to be an appropriate utilization in the system. If it had the proper indication.

Jeffery: Let me clarify that one. The benzodiazepines in our system, there are two classes listed in there twice, so they're under anticonvulsants in one area and as sedative-hypnotics in another area. So the Ativan falls under a sedative-hypnotic and under a psychotropic. Whereas diazepam, it falls under the anticonvulsants.

Lawrence: The intent is for epilepsy, for pediatric neurologists, we were trying to get you through with the diagnosis. We have to figure out the system piece of it. The bigger picture: The DUR Board has a regulation that we are not allowed to reimburse for drugs that are off label unless there is peer reviewed literature or they have supporting compendia. All Medicaids have that across the nation. That is how we are different than commercial payers. It's in the Social Security Act. The first piece of this is if it has an indication and you're clear on that indication, and you're a pediatric neurologist, the goal when our policy was written, is to bypass this entire process. Just like our ADD/ADHD drugs are in a different policy and we have a different policy that handles this in a different bucket. If it is off label use and it's

not supported through an FDA indication, or peer review or compendia, it's a whole other obstacle that we unfortunately have to tackle.

PO: There is enough literature about the .

Lawrence: Yes and that's why it was eventually reimbursed, but it did hit a snag and the process brought it to our attention.

PO: Thank you for bringing it to our attention.

JM: Don't we also have a policy for providing a 3 day fill on denials?

Lawrence: We have a 96-hour.

JM: 96-hour. So you're talking about 4 days. People need to be aware of that in the call center.

Jeffery: The call center is aware of that too. The other thing we are doing at the call center is that if we do receive a renewal PA for somebody who has been stabilized on a medication for a long period of time, they will authorize a 90-day override with the intent that the prescriber will taper that patient off. We understand that it's very bad to just cut someone off their psychotropic medication.

Dr. Edward Lynam - Child Psychiatrist, practiced in Ohio for 12 years after doing training in Pennsylvania and has been in NV for 9 years. I've been dealing with the policy now for years. Delays in treatment, interrupted treatment, hassles for my staff. One of my staff spends 3/4 of her time dealing with parents, pharmacies, doctors, and other people just trying to get this whole process to work for our patients. The amount of time it takes me is extraordinary. I've looked at other states that border Nevada and other states that were mentioned to me by people for Medicaid. I looked at my old states of Pennsylvania and Ohio. As far as I can tell, I've not seen any state that requires even half as many PARs by child psychiatrists. In fact, if I move to another state, I believe I would get about 25% or less, even the most stringent state of all. I believe your policy is way out of line with other states. I don't understand why, but I am done. I'm going to leave the state. I have had it. I'm not going to see any more new patients. I'm phasing out my practice. I believe you will have a hard time retaining child psychiatrists if you retain the policy. Thank you.

Dr. Philip Malinas - Child Psychiatrist to both private practice here in Reno, taking Medicaid patients. I also work in the state of Nevada rural clinic in Carson City seeing Medicaid patients and I've been doing that for 8 years. Prior to that I was in California for 20 years where I treated MediCal. I've always treated this population and plan to continue. To summarize what is going on here from my perspective, since April 1st, we have a new form that has to be faxed. We are not allowed to call in on children anymore. That takes more time than the old system. We now have to

present these citations for off label meds. That takes a lot of time, as you've heard, time that we don't have. The turnaround time on these PA requests is much slower. That's causing interruptions in treatment for our patients. This letter of medical necessity for young children - I haven't had to do one, so I don't know what it is. It's not defined, so I don't know how that's going to work. As Dr. Lynam alluded to, none of this is required by the Medicaid carve-out plans in Nevada, by private plans, or other state Medicaid programs. There must be another way to satisfy regulation 1200, Chapter 1200. My sense is the way you satisfy this is, without requiring each of us to go through this process on each patient, every time (we're talking about so much duplication of effort and time taken away from patients) I assume this could be satisfied by having a (unintelligible). That is if, for example, Welbutrin is used by a child psychiatrists for ADHD, and there is documentation for it, which I've submitted but haven't heard back yet if it got approved, once one of us shows that, or if there's a subcommittee that would put together a formulary, then we could have it put on the formulary, then we know that we can prescribe Welbutrin for ADHD for children. Medicaid can legally reimburse for that because there is peer reviewed literature for that and we're done. And each of us doesn't have to submit that citation to a pharmacy tech in Massachusetts every time. I assume that is how every other state and insurance plan, and Medicaid plan is getting by this and I think that would be the solution.

PO: I appreciate the fact that you're coming to us with a possible solution.

Lawrence: I have to acknowledge Dr. Malinas. He has been very helpful behind the scenes. He gave us several solutions within the first 2 days and that is why the form has been modified multiple times behind the scenes. We applied 5 different suggestions by his comments behind the scenes. We actually have been talking about that. When we talked about the citation list that we sent back to you, what we are trying to figure out is if they have a citation list and it's on one citation list, then we know that that is the approved citation list. What can we do to utilize that as the source document? I want to be careful that we are not confusing that with the preferred drug list, the formulary. Because that's a little bit different. We are not more aggressive than other states. They are doing this similar to other states. What you do see on other states is that they've combined their preferred drug list and have put the FDA indications right on their PDL. That might get a little bit messy. We are trying to quickly look at how we can do one source document. That's going to be a lot of partnership, putting that list together, but we are doing that. There are still going to be drugs that are prescribed that do not have peer review literature and are going to be completely off label, which we are going to still deny. I do have a question about the call-in.

Jeffery: From the call center prospective, they need to have all of that documentation documented. That's why it needs to be in a faxed form rather than called in. Potentially in the future, maybe we can get to the point where you can say "I'm prescribing this based on this article, this is my justification for using it." Maybe we'll get to that point down the road.

DE: Along the same lines, another question too. I've had to do this at another facility where I was working at one time where you're trying to get your information across and all they wanted was emails. My MO is if I can say it in once sentence, I'll text it to you. If I can give it to you in a paragraph, I'll email it to you, but if I have more than 2 questions, I'm going to talk to you. That is the problem that I have with these places that want a fax, or you email all day. You email back and forth, your question, 2 or 3 hours before you hear back and then you have forgotten what your question was in the first place. Does the Call Center have the option to use different methods of communication so a fax for certain things, a call for certain things, and email for others. Put some criteria in there so that it can be done without a whole lot of hassle at times. Personally I would rather do a lot of things electronically. Once I've found an article, if they want an article, I scan it, keep it pdf, save it and then shoot it out to whoever wants that email, or that citation. Can we set something up like that? Because everything we've heard tonight is that we've got a process problem. It's not that the system is broken, but the flow is broken down somewhere.

Lawrence: I appreciate the call, that piece of it. We can definitely look at that piece of it.

DE: The idea of the citation list, would this be something that if one of the practitioners or prescribers wanted to know something, could they go online, or access this somehow and see the literature that's being supported right now that is current, as opposed to going to do a search or their own process?

Lawrence: Yes. That is kind of what I had envisioned. We're starting to put it together. Then it will be a one source document to look at and we could add to it that way we all agree that this is a viable list to use. You could add additional sources if you found one but it would be a good running list at that point in time.

DE: Most the literature out there, when you go to look at something, there are certain stages that are the paragon of how it's going to be done. If you have that, there is no reason to reinvent the wheel.

BS: I just wanted to share something because I've heard it a few times now that our policy is so restrictive and other states don't do what we do. I went through and did a lot of research. I went to each one of the state's Medicaid sites, pulled down their PA forms and their PA policies and I wanted to mention a few of them just so that you can see that we're on par with some of the other states and what they are doing. For Florida, their Medicaid, they do require PA for children aged 6 and under who are prescribed antipsychotic medications, over age 7 who receive multiple prescriptions. Georgia requires a PA for all atypical antipsychotics and then they have what they call Peach Care for kids and they require PA for any children who are younger than FDA approved ages and they also require monitoring plan for safety and effectiveness which is required for each prescription that is prescribed. Illinois requires for children aged 6 and under who receive medication for ADHD

and also under age 8 for any atypical antipsychotic. Maryland is for all children under age 18. They also have a peer review program for mental health medications. So not only do you have so submit the PA, but then it goes to a peer review committee that also has to review and approve. Massachusetts also has a PA for concurrent use of antipsychotic medications and prescriptions in excess of established quantity limits developed by the mental health and pharmacy program. Minnesota, New York, the FFS program requires PA for atypical antipsychotics prescribed to children according to the FDA minimum age and diagnosis criteria. They also have, through Magellan Health, they manage PA for the children statewide. North Carolina has a pretty extensive program. Also they require safety monitoring documentation. Any antipsychotic prescribed without a clinical diagnosis code corresponding to an FDA indication, all ages up through age 17. So you can see we're not the only ones. Pennsylvania, I heard that one mentioned, all antipsychotics for children under age 18, all stimulants and related agents for children under age 4, and all benzos for children and adolescents under age 21. So you can see there are policies not as restrictive as maybe some of us may have thought.

Malinas: Your research is for mostly all antipsychotics. Your policy is all psychotropics, everybody under 18. It looks like other states have targeted antipsychotics which are very expensive and have a lot of side effects. Maybe they have more reasons for scrutiny.

BS: It also depends to if you go to some of these websites, they break it down, so they will have. I'm just sharing the data, just like you did.

Malinas: Just keep in mind, as you work on this, hopefully improving the system, this process problem, as you so well put it, that if it continues to be that every time I prescribe, I've got to make a call, or I've got to fax a form, and then follow up with a call to a pharmacists sometimes, and we all have to do that every time, you're going to clog the system terribly. I don't have time. I see a lot of Medicaid patients and I want to continue, but I don't have the time if it clogs up, I'll just go with other insurances that are easier.

BS: I can appreciate that as well and as another note to share, I'm a licensed foster parent for Washoe County, so I have had these children in my home. They have slept in my home, they have been there for months, so I can appreciate the treatment of these children and what they need, and yes a lot of it can be off label, because sometimes you just run out of options. But like Coleen said, you also want to take into consideration those bad apples. There's a lot out there. So we're just trying to do the best for the greatest good.

Lawrence: So what we want to do is, for psychotropics in general, we want to keep the policy intact. I think that is something the Board has stayed strong and didn't change the policy, but the process. And I think if we continue to work through this specific policy bumps, procedure bumps, like the one you had brought forward,

brought up several to work through, whether it's new patient, continual patient, again it's the PA once a year that we are looking at. A call vs. a fax...those are the kinds of things we want to see what is going on with these. As I've stated before, it's a national trend that we're trying to protect a venerable population. You're all valuable prescribers with us. We want to work through this process. I want to understand the process issues so that we can make this the most seamless process for you to continue it. We can work through the citation list, so we can educate, and make this an opportunity to improve the education on appropriate prescribing.

DE: I think when we went through these initial processes to put together, several years ago, Nevada was the top 5 of providing psychotropics to pediatrics and younger. And we thought, What are we doing wrong, or what aren't we doing in our process. That's when these processes came up and we've never had the outpouring of concern or problems with them until now, so that's what leads me to believe that we went down the right path, but how it's being implemented is where our problem is and we need to take a look at that. Like Paul said too that we appreciate that this has come to our attention that our process is broken, but we feel that the process we put in there to protect the vulnerability of some of these people and maybe we need to go back and look at the process again and see what we need to shake around so that it's easier to work with.

Lawrence: I would definitely share the data. This Board is very strong on data and we just posted our new numbers. They're out on the website for everybody. Our data is still not the most favorable data out there for the number of prescriptions in our 0-4 population. It's still concerning out there for what we have.

Malinas: Concerned with just a number?

Lawrence: Number of prescriptions we have.

Malinas: Is the assumption that that is harming young children, as opposed to treating?

Lawrence: It's the number of prescriptions per child. We have a lot of poly pharmacy occurring still.

Malinas: But you're assuming that the polypharmacy is bad. We don't know that, or do we know that? Or are they cases like Dr.Rodriguez's, or Dr. Larson's, or mine, or Dr. Lynam's?

Lawrence: It's per case.

(Group talking over each other)

Malinas: Thus being at the top is bad. Maybe it's just that we have child psychiatrists who are treating tough cases, prescribing a lot of meds, yes, but are the outcomes bad? Are there emergency room visits? Are there problems?

Lawrence: These are retail pharmacies only. There's no physician administered claims and there are no emergency room claims. These are only retail pharmacy claims.

Malinas: So there's a large number that looks bad for Nevada, but we don't know that it's bad for the patients.

DE: I think, in one to the studies, one of the things we wanted to look into at that time, when we first saw that numbers was ok, do we in Nevada have a higher incidence of these types of disorders that need to be treated, as opposed to other states, and if so, why is that? Maybe we have an issue with more people having these conditions here, we have a public health issue going on here that we need to take a look at, not just that we're over prescribing the drugs. Therefore, we have a lot of issues going on out there. That's what is driving this. It's coming down to the fact that, true, maybe our numbers show that we're treating it appropriately, but we don't have anything nationally or federally to show that that is happening. All we have is the stats that show we have a higher proportion of numbers of those drugs and people with those conditions in those age groups. We may need to have a look at a public health issue as opposed to just prescribing. That is what our concern was, why we were having these numbers when there isn't a national brouhaha going on as to why Nevada has more mental health issues in their youth, as opposed to other states. And that's what pushed the emphasis for this.

PO: One of the things we were looking at was the concurrent use of behavioral therapy. That seems to be very poorly documented from what I've seen so far. We want to make sure we're doing the best for these kids. We're all on the same page.

Joe Haas - I'm a psychologist administrator with Washoe County Department of Mental Services and Social Services. I come at this from a little different angle and that's the kids that my agency serves. It seems we have a real dilemma. The rates of prescribing are up in these kids, but also the rates of child welfare in juvenile justice population are astronomically higher in the general population as well. My hope is that the Board can take this and work with Coleen and take a look at an issue that would deal with quality, but put as little burden on the prescribers as possible. To give an example, we, as a juvenile justice system employ two full time workers to link families with services. Sometimes that involves getting them Medicaid, sometimes that involves linking them with a doctor. It took one of my workers who is a Master's degree in counseling who has worked in our system for years, 4 hours to find a child physiatrist on a private insurance plan for a family. Most of the families that I'm advocating for don't have the attention span. They are stressed in multiple areas and they don't have the ability to sustain that kind of an effort or the knowledge base to do that. This worker is also incredibly determined, so it was very

important. It seems to me that some solutions that I've heard that are important is that this quality assurance measure was imposed in part on a system that had challenges already. Potentially looking at how the burden could be shifted to Medicaid, in terms of compiling a list of medicines so that the doctors don't have to, for every case, present the same peer reviewed literature establishing some institutional memory would be important. The other would be to see how your issue with bad apples could be dealt with very strongly from a quality assurance prospective and identifying the prescribing patterns of individual doctors and finding outliers from the data you have, as much as if not more from a PA. The other is to make sure your system doesn't "throw the babies out with the bathwater" because there is a risk of implying that all child psychiatrists are suspect, so you have to do this PA. If you get together with the ones in our community in the north, I think there can be some solutions leveed to really not put the burden back on them. From a buying and selling prospective, it's really hard to find a child physiatrist in our community. If you put more burdens on them, they will go elsewhere and one already has. I'm not sure what we are going to do to fill that gap in our system. It really seems important to keep the good ones happy, as happy as you can. Where you're ready to build a system of quality assurance, you'll build it and no one will come because people will drop off, or they may not see as many Medicaid patients, so that worries me. The other thing that has been helpful in my dealings with Medicaid as we worked to find our kids placement, is the deal with the process issue, by identifying a single point of contact the psychiatrist can call after any smell of a problem, where they can call and say "This is happening." and then that person acts as a guide through the program to solve that problem quickly. I think you'll get docs to stay if they establish good working relationships with someone they can call. We're working with that in our consortium Mental Health of Washoe County. Medicaid takes a beating amongst family members and providers, but nobody really deals with that at an individual level and we're working to set up a form in a way where instead of repeating complaints at meetings that we work with a single point of contact. I've found Medicaid to be responsive in their approvals for residential treatment. We're able to access someone to talk to help us solve a placement issue for kids in need. Those are the kind of things I suggest. I come at this as a psychologist. I don't prescribe. I support behavioral therapies. There's a lot of support nationwide. There was a big report in the LA times recently to show over prescribing at least from that reporter's prospective for child welfare and juvenile justice populations, but I can tell you having worked for 15 years in the public mental health sector, in children's mental health as well as in the juvenile justice, the kids that we see in juvenile justice and child welfare, the ones that have problems, have very severe problems and often times defy a lot of very good treatments, including psychosocial treatments and the innovative approaches that are still based in evidence and not so far an outlier that kids get hurt. The other thing you should know is in social services already legislation has been put into place and a lot of the FFS kids are social services kids where there are dedicated workers that approve medications for social services kids all the persons legally responsible. Those are also peer reviewed by a clinical staff and looked at by physicians both north and south. You should also have a comfort level that some of this is already being done

for at least part of your population. I'd be happy to answer questions, but it really worries me that the kids I see, who need services, whose very placement in the community depend on a medication, are going to go without because it's really hard to find docs right now. If this makes them unhappy, and I'm not hearing a lot of happiness right now, it's going to hurt the kids I see, so that will be my perspective. And I think if you look at some of these and even if it's possible to postpone some of the regulations and go back to see how to easily resolve process issues, make it so docs don't have to repeat. My understanding is now, if you want to prescribe Prozac for someone younger, you have to justify that with peer review potentially over and over again.

Larry Nussbaum - Chief of the Child Division of the University of the Nevada School of Medicine. I've been involved in the public sector, on various Boards, the utilization Board. I want to thank Carl and Coleen because they have been incredibly helpful, not only in this process, but over the last several years. About your question about what we can do about giving the other people a list of the information. The University has set up a list and actually I'm working with Coleen a bit on that. I've got a list of practice parameters for child and adolescent psychiatry that the American Academy of Child and Adolescent Psychiatry has and talks about utilizing meds off label. I hear what's going on and I understand that it's been a very stressful kind of situation for all the people that are both on the Board, as well as people that are on Medicaid. And I guess one of the things that is a real concern is that it sounds like, as a child psychiatrist, that there is a perception that we don't police ourselves very well. That you guys have to take the responsibility of policing us and that we don't identify the bad apples. And I really want to discuss that because I think there is a concern and I think it is that way in all medicine. I think it's that way everywhere and there's not a really good way of determining, in many ways, who is a really good practitioner and who is not. Right now I'm involved with the child welfare program. for the kids in Las Vegas, I do the second level peer reviews on those and some of the bad apples that Coleen has talked about, I've done peer reviews on those and they're really concerning to me as well. The issue is, even though I do peer reviews, if there is not a bad outcome for those kids, even though they are being given poly pharmacy, or huge amounts of medications, or 3-year-olds on 2 different antipsychotics. There's a very difficult way of policing those kinds of people unless something bad happens. So we're really trying to work on that piece of it and to let you know that I don't think that should be your responsibility for determining who's a good physician whether it's a psychiatrist or whatever. One of the things that really needs to be done is us working better in order to help keep kids and adults safer and not to screw them up with medication. Especially kids who are in the midst of developmental crises all the time. That's part of the reason there are not many FDA approvals. Because kids develop and it's hard to do studies for kids when they're changing their neurological stuff every day. So there's a huge placebo effect. There's millions of reasons why pharmaceutical companies don't pay a lot of money for studies. The issue that I see, is not so much from the child psychiatrist because we have access to a lot of this information. We have lists of this stuff and we have it available for child psychiatrists across the state. From the mental health

standpoint and the public health standpoint is that out in the rural areas and even here, and in Vegas, many of these children are being treated with these medications, not by psychiatrists, but by pediatricians, by nurse practitioners, by PAs, by family medicine people. If those people aren't able to prescribe medications for the kids, then it's going to be a disaster and those are the ones I'm really worried about because they are going to say "I can't do this. I don't have this information. It's going to take me forever. I'm seeing kids every five minutes, every seven minutes, every nine minutes. It's a crazy situation, so I'm going to refer those people to a child psychiatrist." There's like 38 of us in the state. I'm really concerned that this is leading, from a public health standpoint, to a disaster. Kids aren't going to get services out in the community, that only will you have problems like Dr. Lyman that's leaving, but there's going to be waiting lists forever and these kids are not going to get services and that's really my worry. How we're going to address that. I don't know the answer. I think the concern about making things difficult for those people and those people not giving treatment to kids is the real disaster, especially with the affordable healthcare plan and how many new Medicaid people under ACA now. It's a public disaster. I'm clearly working with Coleen in some type of way of addressing the system of whether it's poly pharmacy, or how we make the right kinds of medications for kids, but throwing this out in the middle of March and not letting anybody know about it, it kind of took everybody by surprise and it's really created a big crisis and it's kind of where things are at. I want to continue to work on this situation, but we've got to figure out something to do now because it really feels like a mental health crisis.

Coleen: To address the...it's not trying to police I will say that. We're not trying to police the psychiatrists by any means, it is looking at the medical necessity of a psychotropic medication and that's why when we started talking about the list, obviously FDA indications are easier to come up with. Most states have those up on their website. We put it in our web announcement. The psychiatry profession has more readily access to those types of lists that we can come up with and the peer reviewed literature, but coming up with that list together and then putting it back up on a website where it's more accessible for all prescribers, that was the goal.

LN: What happens if Dr. X of Las Vegas, who is a terrible prescriber, and she does all kinds of horrible things and she has access to that list and says "This is a list and this is a study where somebody got Seroquel and Abilify and Trazodone and all of that", what is to stop Dr. X from saying "I'm going to cite those types of things and I'm going to give the medication"?

Coleen: When it comes to the ethics and the scope of the practice, those are left to the Board. We're trying to do the medical necessity in making sure there is proper documentation that support the use of the medication. That's within our scope and what is required to do based upon the act. That is all we're trying to do.

LN: But they go together.

Coleen: They do, but there's only so much that we can come down to. We have literally Congress coming down on us over the last several years, coming down on Medicaid about these types of issues, so we have to make sure that we're using our due diligence that we're having the proper policies around psychotropic medications. The Board has been focusing on this for 8 years. It's definitely not aiming at the practice of just psychiatry on that piece of it. The other thing is about polypharmacy. We're one of the states that actually allows for multiple medications within a class where some states do not. We allow the diagnosis and the other drug if it's treating a separate condition. We're still trying to allow the different...

LN: But there's documentation for that.

Coleen: There's absolute documentation, so we're still trying to allow some of that piece as long as there is documentation. As far as ethics and scope of practice, you're right. That comes down to the Board. We just have to make sure that we're doing our due diligence and I appreciate that piece of "Where is that line?" We take that line as we do with all of our other policies.

DE: One comment I want to make too on that, and again, in part of our discussion, one of the other concerns we had is - I remember a show called "Friday is a long time ago" they had a pharmacist skit on there and his punch line in the comedy was "Got a problem, take a pill." And I think that was what we were concerned about when we're seeing these multiple pharmacies. One time during our discussion, we specifically wanted to have a part in there, especially with psychotropics and antipsychotics, that there was psychotherapy along with it, because the drugs in and of themselves are not going to solve the problem. In some cases, some of these people are in circumstances that we probably couldn't give enough pills. The only thing we could do is give them something to put them out so they're not worried about the environment that is causing the problems they're having. So that's why we came up with some the discussions that we had and we wanted to require a psychotherapy component and then we found out we couldn't do that because it was out of our purview. But that was one of the concerns when we went into some of these things and came up with these PARS. We felt that yes this is a DUR Board, but drugs are not going to solve all the problems. Sometimes the drugs are the problem and that's where we have to find that happy medium. Maybe we are too tight now and maybe we need to lighten up a little in our process, but at the same time we don't want to just allow medication to be prescribed just because it can be, but we want medication to be prescribed with some rationale.

LN: One of the things you'll see in practice parameters is the practice parameters almost always talk about psychotherapy as the first type of choice of treatment for the kids. I agree with that. I probably prescribe less than anybody in the state and take many more kids off of medicines than I wind up putting them on. The practice parameters, being a good child psychiatrist is to attempt to do the least disruptive, the least toxic, the least frightening kind of thing and to do the best kinds of things from the front end and for me that's therapy. Sometimes you have to give

medication to help the therapy go along. Sometimes therapy doesn't work. Sometimes kids are in such a condition that they can't benefit from therapy, so you need to find medication. But that's the standard of practice and that's what the child academy supports and I have no problem with doing that. I think the concern is what is standard of practice and how do you really define that kind of stuff. It's a really complicated kind of issue.

DE: I think the thing that complicates it even more, especially in psychiatry, there's the art of medicine and the science of medicine. I think psychiatry leans more to the art. There's some science to it, but the art of how to tweak this because you can't get samples through spinal fluid like oh, your norepinephrine is up, or your epinephrine is not up, it's just not easy like it is with other medicines.

LN: I think all medicine is art. Even if we don't have CFS levels or whatever, it's the relationship with patients. It doesn't matter if one patient has a physiological issue and another person has the same one, the relationship and what they deal with shows a completely different pattern.

Jeffery: Dr. Nussbaum, I gave you a bunch of my cards. Please, in all honesty, call me. If it's a process issue, please call me or, email me. Our call center does the best they can with the tools they have. They are following orders. If there is a process we can improve, absolutely.

LN: Darryl used the term "Throwing the baby out with the bath water" and I really worry that we're close to that kind of situation.

Dr. Ryan Ley - Child and Adolescent psychiatrist - West Hills Hospital: Just to highlight a couple of processes that have been sort of difficult as it has been implemented. The form went from one page to two pages which, you know, whatever. The call piece - I was told specifically on the phone "We will not accept PAs over the phone." What was maddening about that is that I have a colleague who was in the hospital. He got it for somebody on the phone and what they told him was "Well we can do it for you if you are primary care, or if you were calling from a clinic." And I'm thinking, I'm in a psych hospital. This is emergency stuff. I'm cheap and easy and that is the way I approach medicine in terms of the medication I use and probably a lot of people in the room would attest to the fact, if anything, I under medicate. It's been really difficult with the way the process has been unfurled. Kids aren't getting their meds. Two little clinical vignettes. There was a kid who came into the hospital and he was stable on Topamax and things were good. He ran out and the doc that was prescribing the med tried to get it approved. He sent the form, sent the peer reviewed literature, and followed up with a call, and this was over a period of a couple of days, came back denied. The kid had been stable on the meds, but because he couldn't get it filled, and this is a med that isn't expensive, he came back into the hospital. Now we've got another kid that was suicidal, unstable, went to juvenile detention, we didn't change the meds. I didn't change the dose, I didn't change anything. She went to the pharmacy to get the meds and they said "You've

got to do a PA for every single one of these." Now she's in jail, banging her head and she's in a gown. It's a mess. To go back to your point of "Is this a matter of over prescribing", or is it something that reflects the ills of the state? In Nevada, we're terrible, for mental health. We're the worst. We really are. There was a time for a few years when we were the #1 for unemployment, foreclosures, meth, teen pregnancy, I mean you name it. You have all of these social dynamic issues and I think on some level, we just don't have enough in the way of therapy, infrastructure, and support. I don't want to go on ad nauseam, but it has been really difficult, the process. What was interesting about the change is that I used to always call because it's easier for me. I'm in the hospital, it's hard to send a fax, it's hard to send all of this stuff. Never once was I asked on the phone what the diagnosis was. Not a single time. I wasn't one time asked for the ICD-9 code. I haven't had a denial ever, in the last 3-5 years. That's frustrating because if it wasn't on the form when I faxed it, that would be an automatic denial. When we are looking at are processes, it's important to think of what matters. What are we trying to get out of the whole thing? What we are trying to get out of it is if the medication is indicated. I don't have a problem saying why I'm using something. I do have a problem jumping through 10 hoops to get that done. Medicine is already a terrible mistress and this is making it way more needy.

Coleen: So Dr. Ley, we did change the institutional. There should be an institutional transition upon discharge from an institution. We're definitely working on the call in piece of it. That was one of the changes instituted right away, afterwards. It should have been that when a child is discharged from an institution, they are automatically transitioned to the 90 days to allow for that transition, which is concurrent with what we do on all of our other behavioral health drugs so that shouldn't happen any longer for you. That was one of the immediate changes.

CS: I have a question for Coleen about that. I don't work in the retail pharmacy side of things, but how would a patient, if he were to come in a see Dr. Ley on a Friday night, and you make an adjustment, or he does something. And then on a Monday, or whatever day they are released, they go to a pharmacy, how is that pharmacy going to know that? So when they get that rejection at Wal-greens at 10:00 at night downtown for a med, how does that happen?

Jeffery: The pharmacy should be calling. If it's denied for PA and they need to get a PA through, they should dispense a 96-hour override until they can get the override over to-

CS: So who's calling?

Jeffery: The pharmacy should be calling.

Coleen: All of our PAs have an institutional box that they've been discharged from an institution.

CS: Maybe there is a piece of education that needs to go out to these retail pharmacies and these docs because a lot of times, I don't know, I've never done it. I'm a clinical pharmacist that works with docs and I do all of the PAs and I have frustrations that I've been emailing over the same thing that I can't call anymore. I used be able to call and say "This is what I need." and they would say "But it doesn't fall in this category." and I say "The drug isn't in that category." and they say "I don't care." which is what you get. My point is, I'm wondering if part of the processing is also linked to the electronic communication from maybe Wal-greens to Medicaid. And then that pharmacist gets a rejection and just says "Rejected". So now they're left sitting there saying "I can't give out Wal-greens' drugs, or I'll get fired." So I'm just wondering maybe there's some education on that side because I'm hearing that there's a processing problem, maybe at the call center, there's changes that definitely need to be made. Being able to make these simple calls saying this is the difference. This is why I'm looking at this. And we used to be able to do that all of the time. I've done 100s for doctors.

LN: I think part of the issue is that it was rolled out really, really quickly. I didn't hear about it until March 17 or something that it was going to go into effect on April 1. I think just the rolling out piece of it and not letting providers or pharmacies know that this was going to happen, I think that was a mistake. I think that piece of it has really caused a lot of some of the difficulty. We can always tweak things and make them better, but I think when things are done quickly, it kind of brings on a lot of sense of crisis and I think that's part of what this is about.

CS: Is it normal, Carl, for the pharmacist to get a rejection at the point of sale, to pick of the phone and call to say, how would they know to do that?

Jeffery: Well I think they know to do that, but they get that rejection, they look out there and see 10 people who are waiting for their medications and then they don't do it.

CS: Case in point.

Jeffery: It's easier to tell that patient "It's not covered." and send them out the door than to spend even a couple minutes calling to get that override.

CS: But that's what I'm saying. I think there's a lot of pieces here that are out of process and I don't think there are lots of parts here that are trying to deny the use of any one of your folks' drug. Starting at the pharmacy - It rejects to that pharmacist who doesn't know that they can say hey, we know that, at the rehab level. We have pharmacies call all of the time and say you can't refill that. The drug was just filled 5 days ago. It was filled 5 days ago in a long-term care facility and that patient is now a community patient. There's a communication breakdown. These pharmacists don't know that they can pick up the phone and call and say this patient just got out of the hospital.

Dr. Ley - It's a good point about how it could lead to more lag time too because if someone goes to their pharmacy after being discharged from the hospital and they get there at 8:00 at night, they may not call in the first place, but if they do call, they might send a fax to me and half the time they have the wrong fax. I may not get it until a day later and then start that process. Now if I know that they are Medicaid and that's going to be an issue, I'll do it beforehand, but sometimes I don't know and then I'll only know it when they go to the pharmacy.

Coleen: We can do a quick outreach to our pharmacies on the 96-hour fill. We can do institutional discharge. We can do a couple drugs.

ML: With so many issues with inpatient, to outpatient, to neurology that supposed to be exempt, to psychiatry, is there any reason the policy can't be applied the way it was four weeks ago until a certain date? While this didn't go well, so September 1st, we'll go back to this.

????: We did it for 3 years.

ML: Let's get the list ready and let's get all of these issues covered as best that we can so that we can avoid this crisis, address as many issues that we know about and then implement.

PO: That is something that the Board can address. I think we've received very good input from all of you and I do appreciate it, even if you are leaving the state, sorry to see you go, but I value the input that everybody has shared. We obviously recognize that there is an issue with the process and so I think it is up to the Board now to try to decide what we are going to do now to resolve this problem. Whether we go back and say this didn't work, but we've got ideas of rolling out a list that can be utilized by specialist, or the Family Practice people who want to use that list if a patient has been seen one time by a specialist. We should all work together to resolve this.

JM: I'm really puzzled. Was there in fact some sort of process change that prompted this?

Coleen: That back fill process change would be the letter of medical necessity for the 0-5 year-olds. That was an additional form. And the requesting of a citation for off label medication for peer reviewed literature or compendia. The rest of the PA forms is the actual policy put into checkboxes onto the actual PA form.

JM: But there was some sort of internal change.

????: Do you want to see the two forms? I have the two forms right here if you want to see them.

PO: We've got them.

DE: One more thing. This being the age of electronic medical records. I know there are still some issues with them out there. I just saw an article about them in one of the journals, where they are finding out a lot of the medical records aren't talking to each other like they are supposed to be doing. Can't all this information be sent to the call center electronically from the patients' profiles?

Coleen: Yeah, but the Call Center would have to take the phone call.

DE: I've worked in some situations in inpatients and outpatients where, when we had electronic medical records, I could go look at that patient's profile and you could read the reports on the person, read the progress notes, I could find out what was going on and I could answer some of these questions, whereas if we are not taking advantage of some of the electronic stuff, maybe we need to have some of the electronic reports to transfer as opposed to paper.

Coleen: If you wanted to redo what was occurring, you could implement the old PA form. That would be going back to what was occurring. The policy hasn't changed so you could implement the old PA form.

JM: Why could we do that because that really seems to be the root of the problem?

Coleen: You are more than welcome to do whatever the Board chooses to do. You could do the old PA form if you wanted to.

Jeffery: You talked about electronic records. What the call center sees in the claims data, isn't always, and frequently doesn't match what is on the PA form, so the doctor may say they have been on Risperdal and Zyprexa. And they pull it up and they've been on Geodon and Abilify. So something is not matching up and the call center doesn't know what to do with it. Do they send it back to the provider and ask "Did you prescribe these? Are they seeing another doctor who is writing these?" They're seeing all of this information.

Coleen: That is why we're trying to get better information. That is the issue we brought to the Board last time for better PA forms.

DE: Along the same lines. This was medication reconciliation taking place all along. Isn't the medication reconciliation records somewhere crossing the line that someone, a pharmacist, or a doctor, if someone has looked at this medication reconciliation, and that should solve the problem? Yes we've seen all of these, yes we are not using this one because it failed, or something like that because I see a lot of medication reconciliations. By looking at that medication reconciliation, you can figure out what the problem is. Look at all of these medications this person is on, or maybe some of these things should be gone.

Coleen: You mean in claims that we have behind the scenes, or that is on the form?

DE: My question was aren't these medication reconciliations going to the call center, or aren't the physicians' offices having these medication reconciliations to review?

Coleen: That was the biggest feedback received on the new form, was not wanting to put the medications on the form. That was the biggest feedback on the PA form.

DE: How can you evaluate the therapy if you can't evaluate the medications?

Coleen: That was the largest feedback I received, not wanting to write down the medication profiles.

Dr. Ley: Most of the time the patient has no idea. I mean if their taking Oxycodone, they know exactly how much, how many milligrams....

DE: This has been an actual safety goal since 2004, 2005. And there's emphasis on these in the hospital situation where patients are being discharged. You can't discharge a patient without their medication reconciliation. What's happening to that medication reconciliation, is it being done?

Dr. Ley: I think because all of that info comes to us just for the patient, then we write on the form, then the call center gets the form and they say "They were never on this." all we have is what the patient said they were on.

Jeffery: When you see patients and you say "Let's stop the Abilify. We're going to switch you over to Zyprexa, the patient may not understand they need to stop the first one before taking the new one, so that's what the call center is seeing. It really throws them a curve.

Coleen: That's why the new form. The Board came back last time with the new form to ask for the new information and that's what the second page has, the medication profile list.

CS: I'm not sure how it might work for younger patients, but a lot of time what will happen is they will say they are on the medication for 45 days and we will have no proof of that and they will say they were in the hospital. So they're not paying for the drugs like they are when they go to Walgreens. They've been on the drug and stable on the drug for 45 days. They've been in the hospital, now they are going to rehab where they are maybe under medicated, now we're getting a rejection because we haven't tried drug one, two, or three when in fact, it has all gone on in the hospital and they won't see that data. Then when we try to call, they won't see that and they say no, you have to try one, two, and three.

JM: I'd like to move that we temporarily go back to the old PA form, study it until the next meeting and then have everybody come back here. In the meantime, we need all of you guys to collaborate with us and really work out something that

works for you. It seems like the old form was working, at least as well as it was working. We can at least get back to that point and then see if we can come up with something. The motion will be that we go back to the old PA form until such time that it has been investigated and we come with some other criteria that we can propose in time for public notice, prior to the July meeting.

PO: We have a motion.

Seconded.

DF: For the record, Darrell Faircloth, I wanted to ask what you meant by that, just to clarify there were three items mentioned that were part of the policy changes that were implemented April 1st. I don't know if you intended for those to be reversed in their entirety pending additional development. Was it your intent that only the letter of medical necessity be reversed, or the other changes involved?

JM: All of the implemented changes as of April 1st, whatever they were, stay those changes pending investigation and reformulation of those forms.

Voted ayes across the Board.
Motion Carries.

Laurie Squartsoff - I think this conversation has been particularly helpful and it's really important for us as policies are being designed, that we have the conversations to look at and we have the processes in place with public workshops where we can get input from all of the providers, from the experts on the DUR Board, from all of those who are interested in this particular issue because the last thing is that we need to have a community public health issue related to children with mental health issues. Perhaps that is an alternative that we, as the agency, can work with you so that we can have a public forum where people can share their ideas, share their concerns, and can come up and with consensus on how we can continue to move this conversation forward because it's obviously one that's really important for us as a State and one that frankly we have been working on this State for probably longer than 8 years, but one that we need to continue to move the conversation forward, so I offer that form as an opportunity to help everyone who has the best interest of the children at heart, so that we can come up with a policy that we can incrementally work toward.

JM: I would like to bring a point of information up to the pediatric psychiatrists. This is not a closed Board and we are really looking for more participation on it.

Coleen: This was on the agenda last time. The form came up in the agenda last time. That's how it came around because we were discussing this.

JM: So if you guys are here and at the table, it's actually going to help us a lot and you'll feel like you're more a part of the process, which we really welcome also.

Call for 10 minute break.

b. **For Possible Action:** Discussion and possible adoption of policy and delivery model for Vivitrol® (naltrexone)
   i. Public comment - Public Comment – Dr. Perry Olshan, Clinical Psychologist with Ademes as the Medical Science Director. I'm going to cover Vivitrol as quick and as articulate as possible so as not to waste anyone's time. Vivitrol has two indications. One is for alcohol dependence for patients able to abstain from alcohol in outpatient settings. The second is for opioid dependence. It is really indicated for prevention of relapse following opioid detoxification. Treatment with Vivitrol should be part of a comprehensive management program that includes psychosocial support. Opioid dependent patients including those being treated for alcohol dependency should be opioid free for 7 to 10 days prior to Vivitrol administration. Vivitrol is a 280 mg, once monthly extended release formulation of naltrexone administered by intramuscular gluteal injection by a healthcare professional. Naltrexone is an opioid antagonist, which is a blocker, which is the active ingredient in Vivitrol. Unlike buprenorphine or methadone, Vivitrol is not an opioid replacement therapy. It does not maintain physiological opioid dependence. Vivitrol does require opioid detoxification prior to use. In patients physically dependent on opioids, Vivitrol will precipitate acute withdrawal when administered. Vivitrol is also not a controlled substance, unlike methadone which is a control 2 and buprenorphine which is a control 3. It's also not associated with the development of tolerance or dependence. There's no potential for abuse or diversion issues. Unlike methadone buprenorphine. Vivitrol is also not aversive therapy and does not cause a disulferam like reaction either as a result of opioid use or alcohol ingestion. There's no withdrawal syndrome associated with discontinuation of Vivitrol. I'm going to jump into the efficacy for both alcohol and opioids. Vivitrol for alcohol was evaluated in a 24 week, placebo controlled, multicenter, double blind, randomized trial with 624 alcohol dependent outpatients receiving psychosocial support. Subjects treated with Vivitrol demonstrated a greater reduction in days of heavy drinking than those treated with placebo. Efficacy for Vivitrol was evident in the first month and maintained over the entire treatment period. In reference to opioid dependence, Vivitrol was evaluated in 24 week, placebo controlled, multicenter, double blind, randomized trial with 250 detoxified opioid dependent outpatients receiving psychosocial support. The percentage of subjects achieving opioid free weeks was significantly greater in the Vivitrol group compared to the placebo group. Complete abstinence was obtained by 23% of subjects in the placebo group compared with 36% of subjects in the Vivitrol group from week 5 to week 24. I'm going to jump into the pharmacoeconomic data. I'll start with alcohol dependence. Published claims database analysis looked at healthcare utilization and cost associated with treatment of alcohol dependence. In patients treated with oral naltrexone, dysulforam, or Acamprosate and Vivitrol. Results show that patients treated with Vivitrol were associated with fewer inpatient detoxification days compared to all other groups. Fewer alcoholism related inpatient days compared to patients receiving dysulforam or Acamprosate and an increase in an outpatient

substance abuse visits compared to all groups. An economic analysis has been completed assessing the retrospective cost for alcohol dependent, commercially insured patients treated with Vivitrol or naltrexone, Acamprosate, or disulfiram. This was from 2006 to 2009. Vivitrol was significantly more cost effective than all 3 oral medications across patient hospital cost parameters. Underpinning this cost effectiveness was longer persistence with therapy among Vivitrol treated patients as compared to other groups and a corresponding pattern of lower rates of admission to inpatient services. I'll touch on the opioid dependence pharmaeconomic data. A 6 month retrospective study of insurance claims assessing total healthcare costs in patients treated with Vivitrol, naltrexone, buprenorphine, and methadone. The results show the total costs per patient was significantly lower in those using Vivitrol compared to methadone and no more expensive than buprenorphine or oral naltrexone due in large part to the fact that patients treated with Vivitrol had fewer inpatient admissions compared to all other groups. Adverse events include: more than 1,100 patients received Vivitrol in preapproved trials. Approximately 700 patients for 6 months, 400 patients for less than one year. The most common adverse events for alcohol dependence included nausea, vomiting, injection site reactions, muscle cramps, dizziness, fatigue, anorexia. In controlled trials, less than 6 months, 9% of patients discontinued Vivitrol due to adverse events compared to 7% with placebo. Jumping to safety information, after opioid detoxification, patients are likely to have reduced tolerance to opioids. Use of opioids after Vivitrol is discontinued, at the end of a dose interval, or missing a dose could result in life threatening opioid detoxification. Attempts to overcome the opioid blockade while on Vivitrol may result in a fatal overdose. Some people on Vivitrol treatment have had severe reactions at the site of injection which I touched on earlier including tissue death. Some of these injection site reactions require surgery.

Coleen: Did you cover the temperature issue?

Olshan: The temperature issue on label indicates the ideal is 46-77 degrees, refrigerated, however it can be outside the refrigerator for 7 days as long as it's not going over the 77 degree heat. Basically the technology is in the microsphere is if it gets hot, it expands, it's already going to.

PO: My question is that you said there was a significant difference in the opioid patients, however, it looks like only 36% of patients remained opioid free. That's a very low number.

JM: Actually if you compare it to buprenorphine therapy where only 6% remained opioid free, it's pretty good.

Olshan: 23% in the placebo group compared to 36% from week 5 to week 24. There’s a study that goes farther out that would show that difference continues. Obviously people who are on Vivitrol are staying on it longer than 3 months.

No other public comment.

Coleen: The Division has asked that this be brought forward to the DUR Board because there is a lot of legislation this year regarding controlled substances and actually this was one of the topics -antagonists - What has happened is because there is so much attention, we already have requests coming in as far as coverage. For us it wasn't a matter of whether we are covering the drug, or whether we are not covering the drug, what the reimbursement was, or anything like that, but when we started receiving the calls, we didn't have policy on it. We didn't have policy as far as how we would cover the drug, what the delivery model was, would it be in an outpatient hospital setting, would it be in a retail pharmacy, would it be in a specialty pharmacy? We didn't have anywhere to point for policy on this. The manufactures were very helpful. We started reaching out and trying to figure out what was going on and what was most safe and effective for the product. That's how I knew the temperature issue. Mary did some research also. Obviously population could be an issue for us, and so we brought it forward to you guys because we need a policy to point to because there is a lot of attention already. It's not a matter for us on whether we are going to cover it or not. We know we want to cover it. We just needed to know. There are some ideas some states are doing through specialty pharmacy. We weren't looking at mandating a buy-in bill. We're not worried about what we call a buy-in bill in our state because everybody comes through an NDC program in billing. So we don't have to worry about duplicate billing in our state. There may be some issues. We don't know that we want to turn it over to a patient to have a patient walking around with it. So do we want to from the pharmacy to the prescriber? Then we have the idea of having the clinics within the pharmacy, or right next door to the pharmacy and how that works. It could be one of those issues where we have to know if they have a specific diagnosis and to let it go through on the claim on that diagnosis. Those types of issues. We just bring it over to you guys because we need a policy to point to because it's already starting to come into our offices.

DE: So basically we are going to follow the guidelines on the attached buprenorphine?

Jeffery: I just included those in there for reference for the buprenorphine. I think what Coleen talked about was maybe limiting it to either specialty pharmacies because right now I've got the utilization date in there. These are all outpatient pharmacies. Not a single one of these claims is billed through a doctor's office.

Coleen: I'm up for suggestions. I just need a policy right now to point to honestly. We had to do research for a patient as to where to find it. It's already coming in through some of the drug ports in our state. They're being referred and we had to do some research as to where. It will be prescribed in a physician's office, or in an outpatient hospital. We have utilization that Carl did run. Carl did you find the utilization?

Jeffery: Yeah. It's in there. We have between 1 and 7 claims per month. It's not a huge utilization yet, but I think it may pick up.

JM: I think the real critical issue on this is not so much the physical properties, but you're dealing with a patient population that is not terribly reliable, and there's opportunity for diversion, so a patient could actually pick up a prescription, give it to somebody else who wants to get clean, not take it, continue with their old ways, and there are ways of verifying compliance with that. It can be tested for in the urine. I think it would be a bad idea to have a retail pharmacy sort of environment. I think this needs to be specialty pharmacy 2 prescriber/injector. That would be the only way I would be comfortable with the criteria for this. There might be some rare exclusion, but to have a patient carry this out with them is just a bad policy. And certainly in Las Vegas, the physical considerations, half the year it's never 77 degrees for 6 months of the year, so it would be subject to outside its normal storage range anyway. This is a valuable product and it should be available. We may also want to include some sort of verification, so that there be some sort of periodic urine testing so that we can verify that the patient is actually using it and actually getting it.

PO: I looked at some of the other states and what they are doing and they are utilizing specialty pharmacy and maybe we could consider maybe the patient has failed on oral Naltraxone, 30 day trial, to see if they are really planning on getting clean. If they have failed that, there is an injection product that can be sent from the specialty pharmacy to the practitioner, who would administer it in an IM injection (they're usually not going to be doing that on their own at home, hopefully) and how often are they using it?

Olshan: Once a month.

PO: Right but is it continuous. Or is it after 3 month course?

Olshan: I think that would be a decision they would make with their healthcare provider.

JM: Is there any PI indication, for example, on some of the buprenorphine products, there's a 6 month recommended and no recommendation to taper.

Olshan: We've got PIs that we've done 3 and 6 months, but our company isn't recommending, again that's with utilization and psychosocial treatment and a healthcare provider. I think that's a discussion you have going into it. It is an injection. It's going to be in your system for a month. You want to have that conversation on the front end.

Coleen: What if you have a physician that is willing to carry that product vs. willing to have a specialty pharmacy ship to them.

DE: How do you monitor that now?

Coleen: We allow for it because we don't have to worry about duplicate billing because they're both billing through the same...I just don't know that we want to mandate it coming through a specialty pharmacy because of access.

Jeffery: I think our intent was to make sure it is administered at the correct place, by the correct person, and the storage is appropriate, so I think either a physician's office, if they're going to buy it and administer and bill for it, that would be fine. Or if there is some way to coordinate the delivery from the pharmacy, keeping it temperature controlled, directly to the prescriber who is going to keep it temperature controlled.

Olshan: I want to address, if you move to a fail first policy, I think you'll be dealing with a population who that in itself, that policy with addicts in general, is a really slippery slope, where if you're looking at the antipsychotics and those types of things, it's a little different. There's a neurophysiology prospective that we're looking at that's already been hijacked. They're coming into the office, their executive functioning is all over the place and just to put that demand on top of them, when they are seeking help, you're going to wind up with a lot more people failing on Vivitrol, rather than just starting there and getting on with their lives and working on what they need to.

Coleen: The one thing we do have is according to SB-459, the Good Samaritan act.

Audience: It's related to naloxone.

Olshan: Not naltrexone.

MO: You have to be withdrawn from...you have to have the opioid.

Olshan: 7-10 days opioid free. There's definitely a washout date in there. You can give a challenge - .25 of oral and you'll know if someone has been using or not. It's going to precipitate withdrawal, but you'll see it in your office which no one really wants to see, but at least you'll know if the patient has been using. Safety is the key here. That's what we're shooting for. You could do a urine test, but if you've got the patient right in front of you, you could do the naloxone challenge.

BS: So if you allow this to be in a physician's office, would you limit the type of physician? Because I know, especially with suboxone and things like that, you have a lot of physicians who are taking advantage and having a suboxone type clinic.

Olshan: You don't have to have any special training to write this script.

BS: That's what I'm saying. Are you going to be able to have any doctor be allowed to administer it? It doesn't matter?

JZ: Does it come in a single dose?

Olshan: Yes. 380mg. Theoretically you could use half of it.
MO: Where do you get the challenge? That's part of the dose? You're just going to give them a little sublingual?

Olshan: You can give an oral challenge, cut it in half, or quarter?

MO: And that's an immediate response?

Olshan: I wouldn't say immediate. I would say in 45 to 60 minutes. You could always do an oral lead in. Someone takes it home. If a patient walks into your office and you have a good history of what they are doing, there's a relationship there. There are definitely precautions you can take before giving the injections. Being conservative is always on the safe side, especially this.

DE: Considering all of the other concerns about how it's difficult for practitioners to get the patients med list, let alone how long they've been off of it, especially if this person has been on opioids. So you're saying that this person has to be off of it for 7-10 days and who are you going to believe that they are telling you that?

Olshan: That's why you give a challenge, a naloxone challenge, or you could do a urine test.

DE: With a urine test, if they've been off of it for 7-10 days, they could still have a positive for opioids, so that wouldn't do it. So basically you're saying you would have to see an opioid withdrawal reaction in the office to know that they still haven't been off the opioids for long enough and tell them to come back in 7-10 days and we'll give them an injection.

Olshan: Right.

DE: So in 7-10 days are you going to go out and get more opioids probably in the meantime. So we really have to have a motivated patient to be able to use this.

Olshan: Or a good support system.

DE: Which is probably what they don't have and why they are using the drugs anyway.

Olshan: There's all kinds of variables you could look at. If someone is coming out of a treatment facility and are maybe detoxed.

JM: There is also a Clinical Opioid Withdrawal Scale (COWS) you could actually use which will give you some indication. Obviously if they are seven days out, I'm

not sure how positive your COWS is going to be, but generally dealing with a lot of these opioid addicted patients, they're pretty savvy and pretty honest, particularly my patients because they are all paying me cash, so they are all very motivated to get clean. You don't have the same motivation in a Medicaid patient. He may be there because of a court order. It's a totally different environment.

Olshan: I think in those individuals, some of the criminal justice populations are getting the injections prior to discharge/release. And then they are being referred to a provider with the Vivitrol already on board.

PO: Do we want to put this under a Prior Authorization criteria that the indication is that it meets the FDA indications, can be obtained from specialty pharmacy to a provider, or a provider can get it directly from a prescriber.

JM: It's also used off label for some other addictions like gambling and things like that.

PO: Do you have any proposed criteria?

Jeffery: I don't have anything documented to propose, but I think the criteria I would propose would be an FDA approved indication. It is dispensed by a pharmacy that is capable of delivering it to the prescriber's office in a temperature controlled means.

PO: Administered by a prescriber.

Jeffery: Or a practitioner.

Coleen: It's a direct delivery to the prescriber.

MG: So it's a physician administered drug, basically.

Jeffery: Yes and then then physician is going to give that and the physician would also be able to bill that. The prescriber's office would also be able to bill, but me personally, I don't think I would put restrictions on it beyond that because when you are looking at rural Nevada, I don't think you have the access to the specialists that are going to need this on a routine basis.

DE: Also thinking along that same lines, in Nevada, pharmacists can administer medications if it's within scope of practice and their training. In a rural area, you might want that patient to come in, if it's a once a month dose, it can be administered at that pharmacy if the pharmacy has the capability of either doing the administration, since they can administer vaccines and other things. They can go through some training to learn how to do this IM, or witness the patient giving themselves the IM injection before they go.

Olshan: I don't see a patient giving themselves the injection.

JM: It has to be given properly. You can't treat it like you're taking some insulin or something.

DE: Maybe we wouldn't necessarily want it to come out of a specialty pharmacy, but it could be dispensed out of a pharmacy, but the pharmacy individuals have to be able to do the administration.

Jeffery: If the pharmacy has to deliver to the point of administration, it's going to be from a practitioner. I think that leaves it open. So if a pharmacist does have that collaborative practice agreement.

DE: There are exceptions in rural areas. There might be some...

BS: I think there is huge opportunity, but I don't think....

Jeffery: If we leave the door open, we don't have to come back in 6 months...

Coleen: If we write it to where a healthcare practitioner has to deliver the medication - As long as we write it so that it's not being delivered to a patient.

JM: I don't see a pharmacist doing a naloxone challenge.

Jeffery: Once they are established and they are coming back for their follow up shots...

Coleen: So I think that is the question. Is that step being requested, to do the challenge?

Olshan: That is our on label.

Coleen: That's on label.

JM: That's on label, yeah.

Coleen: So then the diagnosis is on label also.

MG: If a pharmacist does it, how does the pharmacist know...?

Jeffery: That would be on the prescriber who is writing the prescription for the Vivitrol. They would be the ones who would identify that this patient is opioid free for 7-10 days.

JM: And is a candidate for it. Ok.

PO: So what do we have proposed? Meets FDA guidelines. They've been challenged and that it's administered by the prescriber. If we leave it at that, we're good.

JM: So we're not specifying how it gets delivered to the prescriber, so the patient could potentially pick it up and deliver it to the prescriber? Is that what you're saying?

PO: No. We need to add that. We need a motion.

Audience: Can I take a moment to speak about the drug being administered by the prescriber?

Board: Sure.

????: My name is (inaudible) and I work with Ademes with the Policy and Government Affairs team. We have been doing some work in the state which might be why you've heard about the drug court issues and the like. But also why you see so few prescriptions. This is medication that nobody will be rushing and knocking down doors to get, I can assure you. There won't be people running out and saying "Please let me have your Vivitrol! I want to get clean!" It's usually the other way, as you've mentioned. Looking at what's happening nationwide, we're seeing PAs being removed, not added. Why? Because of the opioid epidemic. In fact, the opioid epidemic has caused SAMHSA to release a grant which they released at the end of March and they listed 18 states that had a huge increase in their opioid epidemic and Nevada was on that list. In fact they are encouraging Nevada to apply for that grant to increase the availability of all medications to treat addiction. There aren't many. There are maybe 7 or 8 at the most. Adding a PA to a medication that has little use that is hard to get a patient to a willing stage and to get them prepared to be opioid free, often that is happening behind the walls of the jails and prisons. We've been talking to the Director of Corrections. We've been talking to the jail in Las Vegas. We're having these discussions because they are dealing with these patients. The other part is, most states, and I've done a lot of work in California, the provider often isn't the person who gives the injection. A medical assistant, a nurse, maybe a PA, it's very hard to find to physicians who actually have a specialty in addiction medicine. It's very hard to find treatment centers that have physicians. Treatment is often the behavioral health level and it's at the cognitive treatment level. There isn't a lot of medication in treatment. There isn't a lot of medication associated with it. Just like we had with our other issue recently. We don't have a lot of doctors with that specialty. We may be adding another layer of complexity by insisting that the physician be the one to administer the injection.

PO: Maybe we can phrase it "The physician's office", that was not my intent. To your comment about not having a Prior Authorization and that being a blockage, I tend to disagree with you there. I think it gives us a little bit of control, the same as we have PA for other meds that are used for addictive behaviors.

????: This is not an addictive medication, however, and many of those other medications, methadone and suboxone, do have and addictive quality. This is the opposite. They're agonist, or partial agonist, and this is an antagonist.

PO: I understand what you're saying, but don't push your envelope too hard. Anybody have any questions? So we need a motion.

JM: I vote that we adopt the PA for Vivitrol based upon the patient meeting the criteria of FDA indicated indications that the product be delivered to the prescriber's office and that the FDA indicated Naloxone challenge be given prior to the injection of the Vivitrol.

Coleen: So for verification, really what we are doing, the PA would be based upon, is the challenge being successful.

JM: I think you want to follow up the challenge right away, so you can specify that the challenge be given prior to the time of the injection.

Coleen: I'm trying to see what the actual clinical criteria would be for the prior authorization. It would be that there was a challenge and that the diagnosis are appropriate.

Jeffery: And now it's going to be enforced because once the PA is approved and in there, any pharmacy will be able to afford it. Enforcing it is going to be a challenge. It's going to be the word of the prescriber, and we can assign it to one pharmacy if we need to.

Coleen: We'll figure it out. I just want to make sure we have the clinical criteria, what the authorization was for, for the challenge.

JM: Do we need a second on that?

PO: I've got a question before we do that. On your amendment, do we want to indicate how long the PA will be good for? How many months?

JM: I would say 6 month prior authorization.

PO: Do we have a second.

DE: Second.

PO: We have a motion and a second for the approval of the prior authorization for naltrexone with the 5 criteria being used for FDA indicated indication, the challenge will be given, delivered directly to the prescriber's office, to be used once per month, and the PA is good for 6 months. Any further discussion?

Voted: Ayes Across the Board.

Motion Carries.

c. **For Possible Action:** Discussion and proposed adoption of prior of clinical prior authorization criteria for Ombitasvir/paritaprevir/ritonavir and dasabuvir (Viekira Pak®).
   i. Public comment on proposed clinical prior authorization criteria.
   Chris Ultzer - Pharmacist - Medical Affairs with AbbVie - Viekira Pak, with or without ribavirin is approved with dosing recommendations for treatment of patients with genotype 1 chronic hepatitis C infection, including those with compensated cirrhosis, HCD HIV co-infection, and liver transplant recipients. Viekira Pak is not recommended for use in patients with decompensated liver disease. Viekira Pak does not require adjustments in patients with mild, moderate, or severe renal impairment. For patients that require ribavirin, further ribavirin prescribing information is available for your information regarding the use for patients with renal impairment. Additionally Viekira Pak can be administered with proton pump inhibiters, such as Omeprazole without directly affecting the direct acting antiviral. In patients with compensated cirrhosis, Viekira Pak is administered with ribavirin. SVR rates were between 92 and 100% in genotype 1A and 1B respectively. Genotype 1B cirrhotic patients required treatment duration of 12 weeks with ribavirin. The dosing duration for genotype 1A cirrhotic patients is 24 weeks, however, 12 weeks may be considered for some patients based on prior treatment history. In patients with HIV co-infection, the recommended treatment duration follows the genotype 1 mono-infected patients. SVR rates were 91 -100% for genotype 1A and 1B patients respectively. Viekira Pak is contraindicated with efavirenz, but not with tenofovir. Any HCV/HIV 1 co-infected patients treated with Viekira Pak should also be on suppressive antiviral drug regimens to reduce the risk of HIV 1 pro use inhibitor drug resistance as a result of the paritaprevir component of Viekira Pak. All direct acting antivirals have drug interactions and these should be assessed before starting therapy per the AASLD guidelines. In open label clinical trials, 99%, or 526 out of 571 of those who achieved an SVR 12 maintained the response for 48 weeks post treatment, or an SVR 48 demonstrating durability of response. In clinical trials, less than 1% of subjects treated with ribavirin had hemoglobin levels decrease to less than 8 grams per deciliter, which is a grade 3. Seven per cent, 101 out of 1,551 patients, of subjects across the phase 3 program underwent ribavirin dose reduction due to decreases in hemoglobin. But of these, 98% achieved an SVR 12. Additionally, a low viralogic failure rate at 2% was observed in clinical trials and the Viekira Pak discontinuation rate due to adverse events was less than 1%. In subjects receiving Viekira Pak with ribavirin, the most commonly reported adverse events, greater than 10% of subjects, were fatigue, nausea, pruritus, insomnia, asthenia, and other skin reactions. In subjects receiving Viekira Pak without ribavirin, the most commonly reported adverse reactions greater than 5% of subjects, were nausea, pruritus, and insomnia. Comprehensive safety and efficacy data for Viekira Pak can be found at rxabbvie.com. If Viekira

Pak is administered with ribavirin, the warnings and cautions for ribavirin do apply. In summary, I am requesting the Board to take this information under consideration as you decide on the PA criteria for Viekira Pak with further consideration of the following points. High SVR rates in genotype 1, naive in treating inexperienced patients, flexibility and duration in treatment of cirrhotic patients, approved dosing in HIV co-infected patients, flexibility in treating patients with mild, moderate, or severe renal impairment, approved dosing of liver transplant patients, and lastly the ability to use concomitantly with patients on Omeprazole, up to 40mg.

Jeffery: Chris, did you get a chance to look at our proposed criteria?

Ultzer: I did actually looked for them, but I did not see them.

Jeffery: Ok.

DE: I was wondering this too, because I was wondering if you had any, because as you were going through your presentation, I think we've covered all the bases on this.

Ultzer: What this testimony, and it's a very scripted testimony, if you haven't figured it out, what it emphasized is really the areas of differentiation. If the previous topic was complex and initiated a lot of debate, this one is obviously very complex and initiates a lot of debate, so we tried to narrow it down to just areas of differentiation.

Jeffery: I think it follows the AASLD guidelines.

PO: We've got in front of us, a proposed PA criteria and Chris, I think you're looking at it right now. In the meantime, does anybody have any questions on this proposal?

Jeffery: It's just a high level overview - It's just another very effective hep-C treatment. I think we wanted to make sure it was getting to the right patient is the point here. So far we've had two claims for it. Right now it's still stopping for PA because it's non-preferred, but the P&T voted to make it preferred at the last meeting. The next time the PDL is updated, it will be preferred.

DE: I'll move to accept the PA criteria.

JM: Second.

PO: Ok, we have a motion and a second to accept the proposed PA criteria for Viekira Pak, any further discussion? Seeing none.

Voted: Ayes across the Board.

Motion carries.

d. **For Possible Action:** Discussion and proposed adoption of prior authorization criteria for Sodium oxybate (Xyrem®)
   i. Public Comment on proposed clinical prior authorization criteria.
   Jill Gardner - Jazz Pharmaceuticals- Medical Scientist and Internist by training - I'm going to take few minutes to go over the indications, warnings, mechanisms of sodium oxybate, as you've already said, known as Xyrem. Sodium oxybate is the sodium salt of GHB and we'll talk about that later. It is indicated for the treatment of narcolepsy for the symptom of cataplexy. Cataplexy is the spontaneous loss of muscle tone. It can be lasting a few seconds to several minutes. The patient is conscious, usually has shallow breathing, but is paralyzed and cannot move. I did say it can be complete, so they could fall to the ground, or partial it could be just the nod of the head. That's the most debilitating aspect of this disorder and then there is the excessive daytime sleepiness, or EDS. This is sleepiness to the extent that is so profound that it's throughout the day and yes there is the possibility of taking naps that could be partially restorative, but within minutes, you have this profound sleepiness again. Sodium oxybate is considered a standard of care by the American Academy of Sleep Medicine. It is the only FDA approved drug for cataplexy in narcolepsy. There are currently 12,000 patients on sodium oxybate in the US. That is in comparison to the 50,000 that are diagnosed with the disorder and another 150,000 that are undiagnosed. It is an orphaned disease because of its prevalence is 0.05. The efficacy study shows that 69% reduction was found in cataplexy over 4 weeks and excessive daytime sleepiness reduction occurred over 8 weeks. A person with narcolepsy is characterized with sleepy/wake instability they're sleepy during the day and paradoxically they have the inability to sleep at night. We call that disruptive nighttime sleep, or DNS. The evidence suggests that there is an autoimmune destruction of certain neurological cells of the brain and that is what causes this inability to maintain wakefulness in the daytime and difficulty sleeping at night. Sodium oxybate, as you are aware, is a schedule 3 drug, so it has moderate to low abuse potential. The FDA recommendation, but it was a requirement too, that it be distributed through a central pharmacy, so there is only one pharmacy and that allows us to control its distribution, its misuse, abuse, and aversion. Historical rates of diversion have been very low, less than 0.001%. There are reports of illicit use of GHB, the illicit form of GHB. These were mostly reports back in the 80's and 90's. Those reports were doses between 18 grams and 250 grams. The maximum therapeutic dose of sodium oxybate is 9 grams. Before a healthcare practitioner can prescribe, they must be educated on the compound, indications, contraindications, side effects, dose administration. They must also check a box and attest to the fact that they have also counseled the patient. We are currently providing a 24-hour on call pharmacist at the central pharmacy and we are working on a new platform. It's a nurse case manager model in which we want a single point of contact for patients where we can do the monitoring, looking at compliance, or adherence, looking at dose changes and things like that. sodium oxybate is a CNS depressant. It has rapid sedation. It can cause clinically significant respiratory depression. It is associated with CNS adverse reactions, such as seizure, coma, and death. The most common side effects, however, are nausea and dizziness. It is contraindicated in combination

with other sedative hypnotics. It is contraindicated with alcohol. A recent study also suggests a 20% dose reduction with Depakote. We found out that it increased levels with sodium oxybate. The dose increments are at 1.5 grams, starting at 3 grams, going to 4.5, 6, 7.5, and 9 grams is the maximum therapy dose. We have patients at all the dose ranges. They are not necessarily at 9, or 6. The dose is split nightly, so you take half when you go to bed, in bed, and then you would wake up 2.5 to 4 hours and then they would take the second dose also in bed. Lastly, I wanted to talk about the mechanism of action, which is hypothetical. We have some evidence, but because it's not complete, I must say it's hypothetical. We believe that the therapeutic effects that we see the benefits for, resolving the cataplexy and reducing the excessive daytime sleepiness, is through the actions of dopamine, which by helping the patient to sleep and sedating the patient, they reduce their release of dopamine. That allows them to have higher levels of dopamine during the day and dopamine is the primary alerting nerve transmitter during the day. When you look at how stimulants, which are alerting agents, they help individuals with excessive sleepiness, they work on the dopamine transporter where they inhibit the reuptake and that keeps circling levels of dopamine to help the patient stay alert during the day. We often see sodium oxybate patients on that agent along with stimulants. It is a common therapy combination. However, stimulants are not indicated for treatment of cataplexy, but sodium oxybate is.

Jeffery: Do you see it prescribed by anybody other than a sleep specialist, or a neurologist?

Gardner: No. But I need to clarify, a sleep specialist because of the way Board certifications go can be in the specialty of neurology, pulmonology, psychiatry.

JM: I noticed that you didn't mention anything about an MSLT to verify the condition. Is that part of your PI, or anything?

Gardner: Yes. That's a whole other discussion, the diagnostic criteria. That has been propagated by the sleep medicine academy and those are very clear and you can refer to those - The ICSD3.

JM: Should we require that they have an MSLT to verify the diagnosis?

Coleen: Is that in your indication?

Gardner: The criteria gives you several ways to diagnose. You can diagnose by a spinal tap and getting CSF fluid to measure the low cells. That's really only done in research by Stanford and other centers of excellence. The other is a clinical diagnosis of the signs and symptoms, but the recommendations is like to have one objective measure and that objective measure could be a PSG, where you see a short REM latency within the first 15 minutes, or you could go ahead and do an MSLT. Usually you do a PSG and an MSLT. MSLTs are expensive and so the academy is

going away towards one objective test as opposed to two. There's evidence of where you could require both, but some only require the PSG.

PO: The other narcolepsy agents are not indicated for cataplexy, correct?

Gardner: Right. This is the only agent so far.

PO: Is Xyrem indicated for narcolepsy also?

Gardner: Yes. Specific to those two symptoms. Cataplexy and EDS. There are three other symptoms, but I don't believe there are other agents that are indicated for the, there are 5 symptoms it's a pentad. It's certain dreams that are very violent in thought and it causes you to be awakened and frightened, sleep paralysis, and disruptive nighttime sleep. We know it's associated, but there are no drugs that are specifically indicated for that.

JM: This certainly doesn't seem like it would be a first time drug for EDS for excessive daytime sleepiness, so I think that should be some sort of criteria in there as...

Gardner: What we see in practice is that it is definitely a drug of choice for cataplexy. Cataplexy is so profound. Cataplexy is triggered by emotions and it is often humor. So these patients end up living with a very flat affect because if they laugh, they could go into cataplexy.

JM: It seems to me that the dopamine receptor is screwed up and that's where the CMT fits into that.

Gardner: And we think that is the key and we are researching that.

Jonathan Willfield - Jazz Pharmaceuticals - The only thing I would say about the MSLT is that typically when a patient goes in for a PSG and then they go through and they have some sort of diagnosis, if they suspect after that PSG that possibly the patient has narcolepsy, then the sleep specialist would want to see an MSLT after. Which then you would have to go in for a PSG again and then an MSLT and that is very exhaustive and very challenging for a schedule and it's expensive.

DE: Have either of you see the prior auth criteria?

Willfield: I have not.

DE: What do we have so far, Carl?

Jeffery: Right now coverage and limitations say, and we also include the Provigil and Nuvigil in here for the treatment. It says authorization will be given for following criteria: Used for an FDA approved indication and the request for sodium

oxybate one of the following: 1. The request is submitted by a neurologist or sleep specialist, or there's documentation that the recipient has had consultation with a neurologist or a sleep specialist. Then it would be approved for one year. If they are treating for narcolepsy, maybe we should have some kind of step through Provigil, or Nuvigil before moving on to this one. Because this certainly isn't first line for general narcolepsy.

DE: This doesn't make any mention of cataplexy.

Jeffery: It would be an approved indication.

PO: So what you're proposing is the coverage and limitations would indicate that the use would be for cataplexy or narcolepsy if failed either armodafinil, or modafinil.

Jeffery: Correct.

MG: Clarification: You have here the agents for narcolepsy are the Provigil and the Nuvigil and then down below it says authorization will be given if the criteria are met requests for sodium on one of the following. Does that mean there is criteria for one of them and not all of them, or are they all...

Jeffery: If the request was for Provigil, they would only need the FDA approved indication.

MG: So should we even take them out, because that is true for every drug.

Jeffery: So why don't we document or submit that indication to the call center or on the claim form.

DE: As I read this and understand this, if we're treating for narcolepsy, we can use any of these. So is Nuvigil or Provigil to be used before we use Xyrem, or would Xyrem be used with all of these whenever we are treating narcolepsy.

PO: For narcolepsy, you have to fail the first two.

Gardner: I failed to mention that 70% of narcoleptics have varying degrees of cataplexy. The stimulants help to treat excessive sleepiness, but they don't treat the cataplexy.

DE: That's what I gathered from your presentation. If they have narcolepsy, we can use these first two products. Your product is more selective in the fact that if they have narcolepsy and cataplexy, this is the one to go with. Even if it's in conjunction with the other one. We wouldn't want to put Nuvigil and Provigil on someone with narcolepsy and cataplexy, but we could have Nuvigil, Provigil, and Xyrem if they have cataplexy and/or if the narcolepsy is not effectively with the awakening agent.

Gardner: Yes. The stimulants help to keep the person awake, the Xyrem helps to resolve the cataplexy which is absolutely essential to restoring a normal life. Some patients, 30%, are able to be on Xyrem alone because it does treat the EDS and, but in 80% of our studies most of them are on a combination.

MO: Quick question, in the cataplexy in narcolepsy, when you say that in this trial where they were withdrawn from the sodium oxybate and they experienced significant increase in cataplexy attacks, that's back to their baseline, right.

Gardner: Yes. That's to show the rebound that in fact the treatment was durable. So we withdrew it to prove that symptoms would return.

MO: And they just went back to base.

Gardner: Yes. They didn't increase.

PO: Can we get a motion to approve the prior authorization for these agents?

Willworth: Xyrem does have an indication for use with narcolepsy type 2 without cataplexy for excessive daytime sleepiness, with or without induction with an awakening agent.

CS: I think we're trying to use Nuvigil or Provigil for narcolepsy alone. If they fail that, they can have Xyrem, or if they have narcolepsy with cataplexy, then they can have Xyrem regardless. That's my motion.

JM: Seconded.

PO: We have the motion and the second. Further discussion? None. All those in favor of the revised proposed prior authorization criteria for narcolepsy agents, say Aye.

Voted Ayes across the Board.

Motion carries.

e. **For Possible Action:** Discussion and proposed adoption of updated clinical prior authorization criteria for Omalizumab (Xolair®).
   i. Public comment on proposed clinical prior authorization criteria. – None.

Jeffery: One of the reasons we brought this back to the Board is to include the allergists and the immunologists and we had some people upset with us because we left them out. I think we wanted to include some other ones into that. Add the allergists and the immunologists because I think we only had pulmonologist for the asthma and we had dermatologists and rheumatologists for the chronic uticaria. We

wanted to add the allergists and immunologists too. Also we added the dosage chart that follows the FDA indications.

PO: Any discussion? Can I get a motion to approve the proposed updated prior authorization criteria for Xolair?

DE: So moved.

PO: Second?

DE: Seconded.
PO: We've got a motion and a second. Any further discussion?

PO: Call for the vote. All those in favor say Aye.

Ayes across the Board.

Motion Carries.

f. **For Possible Action:** Discussion and proposed adoption of prior authorization criteria for Naproxen/esomeprazole magnesium (Vimovo®)
   i. Public Comment on proposed clinical prior authorization criteria. Sal Fofaso: I represent the company, but have no comment. Just need to know the PA criteria for the Vimovo and Rayos. I represent both companies.

   Jeffery: Vimovo specifically is a combination naproxen and esmeprazole and as you know both products are available separately. We proposed the criteria similar to the Duexis a couple of meetings ago. We proposed the criteria that it's for an FDA approved indication, have tried both agents independently before moving to the combination agent. The proposed criteria in here, we also include arthrotec as well. We've updated those.

   JM: Why are we including Arthrotec in here?

   Jeffery: It's just another combination. To treat everything fairly, there is another combination. But we can strike that if you don't see it as appropriate.

   JM: Well it's in a totally different class drug as a secondary agent.

   PO: The misoprostol cannot get over the counter. The others are all over the counter.

   Jeffery: We can certainly strike that, if that is how you feel.

   PO: Anybody wish to make a motion?

DE: So moved.

PO: We have a motion to approve the prior authorization criteria as presented with the removal of the Arthrotec products and their quantity limitations also. We have that motion.

PO: We have a second?

JM: Second.

PO: Any further discussion?

JM: I think there is a solution in search of a problem. I don't see this at as all being any real...you're taking two ten dollar drugs and making them $1,000s. I don't understand why we have to have these in the formulary. I mean we have to have them in the formulary, but why do we have to approve it?

CS: But you're saying we're approving this if they have failed the individual agents. How does that happen? If they fail them, how are they going to do with them together? Are they just not purchasing them? Both of these drugs are available generically, over the counter. It's an FDA approved product.

Lawrence: As long as the manufacturer is participating in the drug rebate program, and is an FDA approved drug and is not part of our excluded categories such as weight loss, cosmetic, those types of things, we do have to make them available. Now, you do have choices, so if there appropriate clinical step therapy, not based upon cost, but if there are step therapy items that you would like to do, clinically, you could do something to that effect.

JM: If they failed either one of the components, then they probably are not appropriate to take the combination. It defies logic.

PO: We do have a motion and a second.

PO: So one way or another, this drug has to be on there.

Lawrence: We can research what some other states are doing on that too, from a criteria prospective.

PO: Next time we'll look at that in the meantime, we have a motion and a second. All those in favor in passing this as it is presented with the deletion of one element, say Aye.

Ayes: 4

Nays: 2

Motion Passes.

g. **For Possible Action:** Discussion and proposed adoption of updated clinical prior authorization criteria for Hydrocodone extended release (Zohydro ER®).

Public comment on proposed clinical prior authorization criteria. Dr. Harold Gould - Director of Medical Affairs at Zogenix which manufactures and markets Zohydro ER, hydrocodone bitartrate, extended release capsules. We propose to remove the 5 dose per month quantity limit for Zohydro ER and propose that the non-preferred formulary status quantity limit for Zohydro ER be 60 capsules for 10, 15, 20, 30, 40, and 50 mg with a step through the preferred extended release analgesics, or immediate release hydrocodone for patients with a diagnosis of chronic pain taking hydrocodone for at least 90 days. Like all other extended release, long acting opioids, Zohydro ER is a schedule 2 opioid indicated for the management of pain severe enough to require daily, around the clock, long term opioid treatment for which alternative treatment options are inadequate. Zohydro ER is the first single entity hydrocodone containing product which was intended to fill an unmet medical need for the estimated 2.4 million Americans currently taking hydrocodone combination products such as Vicodin chronically to manage their chronic pain. Because these products contain acetaminophen, patients who are taking them chronically are at risk of developing acetaminophen induced liver injury, which often times results in death, or a need for a liver transplant. Approximately 2/3 of all unintentional, non-suicide acetaminophen overdoses in the US occurred in patients taking immediate release hydrocodone combination products. Further these products require patients to take doses 4-6 times per day, resulting in multiple peaks and troughs in blood levels of medication resulting in suboptimal pain control and the need to wake up in the middle of the night to take their medication. Zohydro ER is an extended release formulation that is dosed every 12 hours resulting in less peaks and troughs throughout the entire day and night. On January 30th of this year, the new formulation for Zohydro ER was approved. Zohydro ER with BeadTek. The capsules now contain both beads of polyethylene oxide, a well-known pharmaceutical excipient and beads of hydrocodone. The beads are indistinguishable from one another and a viscos immediately forms when the contents of the capsules are crushed or dissolved in liquids or solids. The new formulation should retain the same efficacy and pharmacokinetic profile as the original and the clinical experience is expected to be similar to the original formulation, allowing providers to continue to prescribe the same way. The clinical significance of BeadTek on abuse and misuse has not been established. As detailed in the Zohydro ER prescribing information, Zohydro has the same abuse liability as all other extended release, long acting opioids. Much misinformation in the media exists with regard to the potency of Zohydro ER relative to both immediate release hydrocodone combination products and other extended release opioids. The fact is that hydrocodone and Zohydro ER has the exact same potency as any other hydrocodone containing products. Hydrocodone is actually a less potent opioid than other marketed opioids such as oxymorphone, hydromorphone, or fentanyl. Our company takes prescription opioid abuse, misuse, and aversion very seriously and

we were the first company to have implemented from the launch of the product, safe use initiatives that go above and beyond the mandated US Food and Drug Administration risk evaluation and mitigation strategies. We believe strongly that abuse deterrents requires a systems approach and not just a formulation. This system approach incorporates the FDA REMS for extended release opioids regulation under schedule 2 prescribing requirements, industry leading responsible commercialization practices, and implementation of a comprehensive approach to surveillance, ensuring that the appropriate use of Zohydro ER by the right prescriber, for the right patient, is a priority for Zogenix. As abuse is often laid to the availability of the product, our current DA quota for hydrocodone is less than 1/100 that of immediate release hydrocodone containing products. We provide educational materials to healthcare professionals and to patients. For prescribers this education consists of helping to assess which patient is the right patient for opioid therapy, as well as assessing the development of abhorrent behaviors and ongoing monitoring to ensure our patients are continuing to get the benefits of both pain relief and functional improvement. For patients, we provide education on taking their medication appropriately and on their responsibility that medication is being stored properly to reduce the risk of diversion. To that end, we provide locking caps, free of charge, as well as home medication safes at a reduced cost to patients. To conclude, Zohydro ER with BeadTek is designed to be a better alternative to those patients taking hydrocodone / acetaminophen combination for greater than 90 days, for severe, chronic pain by reducing the risk of acetaminophen induced liver toxicity, provides less frequent every 12 hour dosing. Zohydro ER provides a consistent pharmacokinetic profile, minimizing peaks and troughs. Lastly, the patient should not notice any change in efficacy or tolerability with Zohydro ER with BeadTek from the original formulation.

Jeffery: The FDA has 5 levels of abuse deterrent technology. Have you been evaluated through that program? What's your status?

Gould: We currently have our abuse liability studies that are ongoing. They should be complete shortly with the intent to have a label change by the end of the year.

PO: We have proposed criteria here in front of us. When we talked on the phone, there was a typo in here.

Jeffery: I don't think it's a typo. The more I looked at it, I think it identifies the drug product.

JM: How did we arrive at the limitations? Number per day for example.

Jeffery: That's from the typical package, or typical dose.

JM: Except for the oxymorphone, they are all about 100mg morphine equivalent a day limit which is maybe politically correct, but I'm not sure it's clinically adequate

in all cases. For example the Hysingla is 120 mg once a day, but we're limiting Zohydro to 100mg a day.

Jeffery: It's just based on units available.

JM: But there are some lower dosage units available besides 50.

Jeffery: It's a maximum quantity, so if they wanted more, they would have to step up to the higher dose.

JM: But they can't get more than 100mg, 2 tablets a day.

Jeffery: Not with this quantity. They would need another PA.

JM: Can they get a Prior Auth to exceed the quantity limit?

Jeffery: Yes. They would need to provide the justification for why they need the higher dose.

Lawrence: Does this one allow Prior Authorization to exceed quantity limitations?

Jeffery: We don't have any criteria that would state...

Lawrence: This was not a hard block, right?

Jeffery: There's no criteria that we have documented here of why they would exceed the criteria.

JM: There's no step therapy required either.

Jeffery: It would be a clinical judgment on the pharmacist.

PO: What is our current quantity limitation?

Jeffery: Right now for the Zohydro, it's that 5 per 30 days. It's really low.

JM: So just a temporary.

Jeffery: Yes. The other ones are similar to this. It's in chapter 1200.

MG: So are these drugs on the bottom, Avinza and Kadian, are they subject to this criteria also?

Jeffery: Yes.

JZ: Basically all of them are subject to the same criteria. But Zohydro is significantly lower quantity limits. So all of the Zohydro ER products coming out right now, does it all have abuse deterrent technology in it now?

Gould: As of two weeks from now, May 4th, it will be available with the BeadTek in it. So right now we've bled out all of the original formulation out of the supply chain. So as soon as the new, the manufacturer releases it, it will go right into the supply chain. There should be very little of the original formulation left.

JM: There's kind of a disparity here. We allow up to 400 mg of Kadian a day, which is obviously 4 times the morphine equivalent of the hydrocodone. Why are we arbitrarily cutting these limits?

Jeffery: It's based on how frequently it's dosed. Kadian is typically every 12 hours, Avinza is once a day.

JM: But still, to take total accounts, that is what they are getting a day, is 400 mg.

Jeffery: If you want to add some quantity limits on total morphine equivalent doses, we can do those too.

Lawrence: When it first came out, you guys wanted to see what the utilization was. That's why you didn't utilize that number from the very beginning. And that is why it was reagendized. When it first came out, that was your plan, to relook at the quantity limitations. That's why you have taken that first number from the very beginning.

Jennifer Stanton: On your proposed criteria, it says severe pain that requires daily, around the clock, long term, opioid therapy and documentation that alternative therapy…an example is immediate release opioids is ineffective.

Jeffery: Ineffective, not tolerated, it goes on.

Stanton: But there's no step through like a generic.

Jeffery: Not in here. We still have the preferred drug list. This is something for the preferred drug list.

MO: So a patient who has been on 90 days + of immediate release hydrocodone combination, but they are doing fine, but they are pushing the mg limit for acetaminophen, they still would be doing fine. They wouldn't meet that criteria, because based on that, they wouldn't be doing poorly. It wouldn't be ineffective, it's just that they are at risk for other problems, so would they be allowed to be switched?

Jeffery: I think that would fall into the not tolerated. If they are not achieving control, then they can certainly move to something else.

JM: I guess I'm just concerned about the disparity between the totally mg daily limits. If we can go up to 400 mg of morphine, I think we should be able to go up 400mg Zohydro. Although that's certainly not within package or PI, or whatever. I think as a clinician, you have to use what is clinically indicated, or even in the case of Avinza, it's 320mg of that. I think these numbers tend to be artificial in terms of that.

Jeffery: I think these are just based on the number of times they're given and we can certainly talk about it. Kadian, 2 per day at a max of 100.

JM: I wouldn't limit it. I have a lot of patients on 200-300mg. I've got patients on 600mg of morphine, or even more than that. It just depends on what is clinically indicated. Obviously a PA override could be done.

Jeffery: This is a starting dose. This is for your average.

JM: The problem we see is what happens when these patients go to the pharmacy, just like Chris was saying, the pharmacist says it's denied. Be that as it may, the pharmacist is supposed to notify us by state law, that the prescription was denied, but they don't and they just tell a patient that it was denied and the patient walks off and two weeks later they finally call and they've used up all the stash that they've hoarded and now they are desperate and we ask what happened and they say it wasn't approved. Then we ask why didn't they call? They say the pharmacist said it wasn't going to be approved, so they gave up. The problem is that you create these artificial boundaries at the retail level. They tend to be a big barrier to dispensing. Obviously it's not Zohydro's problem, but it's the patient's problem. I would like to address that because it really is becoming a major problem we're seeing all the time.

CS: That's my concern. They come in to see you and they are your last patient on Friday. They don't have any and because it's schedule 2, obviously it makes it more difficult. You go home and they have no drug and the pharmacy...now you want them to have 150 mg, however you prescribe it. Now they can't even say "I can give you 100." It puts everybody in a weird spot. Then you end up with the other issue of pharmacists not wanting to carry these schedule 2 drugs.

JM: And they probably won't for this one either. They'll order it and get it in the next day or two days.

CS: Is there a dose that would be reasonable?

JM: I think the 2 per day is reasonable for Zohydro, but I think it's an artificially low number. I would go for 3 a day to give you a little more latitude. You're a little bit more than the Avinza, or Kadian dose, so.

Gould: In our clinical trial, the pivotal phase 3 trial, they are allowed to go up to a dose of 200mg a day. But they were capped. If they needed more than that, they weren't even allowed to continue in the clinical trial. We had capped it internally at 200mg a day.

JM: But there were people who could have used more than that.

Gould: There were a few patients that didn't qualify for the study because they couldn't stabilize their dose.

JM: The FDA would probably look very askew at that and say that you guys are promoting drug use and drug abuse and overuse.

CS: My question, if we put a maximum, at what point would you like to move somebody from Zohydro? If they got to 200mg and weren't achieving the level of pain management that they needed, would you want to move that up, or would you decide to move them on to something else?

JM: It would depend on a lot of things. It would depend on what they could get coverage for, on an override on a quantity limit. If they don't respond to 200mg, could you go to Fentanyl, and give you 200 mics an hour of Fentanyl. I actually have people on 400 mics an hour.

PO: I think one of the main concerns is with the quantity limit of 5. Whether we shouldn't maybe consider revisiting that quantity limit right now and for next, or future meeting to look at the whole thing.

JM: I could propose the motion to increase the quantity limit to 90 or 60 a month and then we can clean it up and have some sort of logical way of dealing with this. There's a lot more going on here.

JM: We're talking about removing the quantity limit of 5 on the Zohydro and bumping that up to 60, or 90 and then allow quantity limit overrides as necessary as a motion.

Jeffery: Which one? 60, or 90?

PO: 60, for now.

PO: We have a motion to remove the 5 quantity limit and raise it to 60 for Zohydro. We will bring this back to the next meeting to discuss the entire class.

Voted: Ayes Across the Board.

Motion Carries.

h. **For Possible Action:** Discussion and proposed adoption of updated clinical prior authorization criteria for Prednisone delayed-release (Rayos®).
   i. Public comment on proposed clinical prior authorization criteria. None.
   ii. Presentation of utilization and clinical information.
   Jeffery: No utilization on this one yet. 1, 2, and 3mg extended release prednisone tablet. It may have some benefits to it. I think there may be some more step to it products that may be more appropriate, like immediate release prednisone.

   JM: Is it the idea that it reduces GI complications?

   Jeffery: I don't think it does that. You can take regular prednisone once a day, so I honestly don't know what the point is.

   JM: I will make a motion to make failure of immediate release prednisone a criteria for prescribing the extended release.

   Board: Second.

   PO: All those in favor of accepting the criteria exactly as proposed say aye.

   Ayes across the Board.

   Motion Carries.

7. Public Comment on any DUR Board Requested Report

8. DUR Board Requested Reports

a. Report on diabetic patient compliance for blood glucose monitoring receiving insulin
   Jeffery: Skipping to more interesting reports. I pulled the number of patients on insulin without getting test strips. There were several patients, almost 4,000 recipients on Medicaid are getting some form of insulin, but not having any claim for any test strips in the past year. This is a little concerning. I separate it out by product, so you can see the Lantus, almost 1,000 claims but none of these patients have gotten test strips. Potentially, if they are Medicare B also, they could only be getting them through Medicare B, so there's a possibility, but that would be relatively small.

   PO: This one would be a good one to drill down into to see the ages.

   Jeffery: Yes to see if they are all Medicare B.

   MO: Is this at point of pick up, or that has at least been ordered to the pharmacy?

Jeffery: I took all the patients who had a claim for insulin and then I took all of those patients and I matched them to every claim that had test strips, so these are the people fell out, who didn't have a claim for test strips who were on insulin. I didn't account for Medicare B, so I'll go back and look at that.

Lawrence: That is something we can turn over to the healthcare guidance program.

b. Report on Guaifenesin with Codeine Utilization.
Jeffery: Skipping down again to the Guaifenesin - Average claim per quantity here is averaging about 180 mls, per claim. It wasn't as high, so I don't know if we want to put similar quantity limits. But we don't have any quantity limits on this one yet.

8. Public Comment on any Standard DUR Report - None

9. Standard DUR Reports

10. Closing Discussion

a. Public comments on any subject.
b. Date and location of the next meeting.
   i. July 23rd maybe. TBD. Evening meeting is working well. Thursday is still best.

c. Adjournment.

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 1

Thank you for taking our survey. Your response is very important to us.

OMB approved # 0938-0659

MEDICAID DRUG UTILIZATION REVIEW ANNUAL REPORT

FEDERAL FISCAL YEAR 2014

Section 1927(g)(3)(D) of the Social Security Act requires each State to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program. Such reports are to include: descriptions of the nature and scope of the prospective and retrospective DUR programs; a summary of the interventions used in retrospective DUR and an assessment of the education program; a description of DUR Board activities; and an assessment of the DUR program's impact on quality of care as well as any cost savings generated by the program.

This report is to cover the period October 1, 2013 to September 30, 2014 and is due for submission to CMS Central Office by no later tha June 30, 2015. Answering the attached questions and returning the requested materials as attachments to the report will constitute full compliance with the above-mentioned statutory requirement.

If you have any questions regarding this survey instrument or the DUR annual report, please contact CMS at : DURPolicy@cms.hhs.gov

DUR ANNUAL REPORT

INSTRUCTIONS:Nomenclature Format for Attachments

States: Please use the standardized format for naming attachments.

ATT#-FFY-State Abbrev-Abbreviated Report name (NO SPACES!)

Example for Arizona: (each state should insert their State code)

Attachments:

ATT1-2014-AZ-POCCR (Pharmacy Oral Counseling Compliance Report)
ATT2-2014-AZ-REOS (RetroDUR Educational Outreach Summary)
ATT3-2014-AZ-SDBA (Summary of DUR BD Activities)
ATT4-2014-AZ-GDSP (Generic Drug Substitution Policies)
ATT5-2014-AZ-CSCAM (Cost Savings/Cost Avoidance Methodology)
ATT6-2014-AZ-IPN (Innovative Practices Narrative)
ATT7-2014-AZ-EAS (E-Prescribing Activity Summary)
ATT8-2014-AZ-ES (Executive Summary)

CMS-R-153 (05/2017)

Please print a copy of this section for your records before clicking "NEXT" button.

Next

0%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 2

1. I. DEMOGRAPHIC INFORMATION

I-1. State Name Abbreviation *

-- Please Select --

2. I-2. MEDICAID AGENCY INFORMATION

Identify State person responsible for DUR Annual Report preparation.

I-2-1. Name *

Carl Jeffery

3. I-2-2. Email Address: *

carl.jeffery@catamaranrx.com

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

7757371877

CMS-R-153 (05/2017)

Please print a copy of this section for your records before clicking "NEXT" button.

Back Next

8%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 3

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 : *

Catamaran

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

No

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

Other

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

Medispan

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

No

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

Medispan provides the criteria, the DUR Board does not review or approve new criteria.

12. II-5. When the pharmacist receives a Pro DUR 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

13. II-6. Do you receive and review periodic reports from your ProDUR contractor providing individual pharmacy provider activity in summary and in detail? *

Yes

14. If answer to II-6 above is "Yes", how often is the report received by the agency? *

Quarterly

15. a) If you receive reports, do you follow-up with those providers who routinely override with interventions? *

No

16. II-7. Early Refill:

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

	Percentage
Non-controlled drugs: *	80%
Controlled drugs: *	90%

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

*

Yes

18. If answer to (b) above is 'Yes', who obtains authorization? *

Either

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

Yes

20. If answer to (c) above is 'Yes', who obtains authorization? *

Either

21. II-8. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your system allow the pharmacist to override for situations such as: *

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

22. If answer to II-8 above is "c) Other and select 'Yes' ", please provide details:

23. II-9. Does your system have an accumulation edit to prevent patients from obtaining additional refills during the calendar year? *

Yes

24. II-10. Has the state provided DUR criteria data requested on Table 1 – Top 10 Pro DUR Alerts by Problem Type indicating by problem type those criteria with the most significant severity level reviewed by the DUR Board? *

Yes

25. TABLE 1 – Top 10 PROSPECTIVE DUR CRITERIA REVIEWED BY DUR BOARD

Indicate by problem type those criteria with the most significant severity levels that were reviewed in-depth by DUR Board.

FOR EACH PROBLEM TYPE BELOW IN THE FIRST COLUMN LIST THE DRUGS/ DRUG CATEGORY/ DISEASE COMBINATIONS FOR WHICH DUR BOARD CONDUCTED IN-DEPTH REVIEWS.

PROBLEM TYPE KEY:
INAPPROPRIATE - IA; THERAPEUTIC - TC; DRUG DRUG - D/D; DRUG ALLERGY - D/A; DRUG DISEASE – D/Dis;

	AHFS TC (Level 2)	AHFS
IA DOSE1	Eye, Ear, Nose & Throat Preparations	Antitussives
IA DOSE2	Central Nervous System Agents	Analgesics and Antip
IA DOSE3	-- Please Select --	-- Please Select --
TC DUPLICATION1	-- Please Select --	-- Please Select --
TC DUPLICATION2	-- Please Select --	-- Please Select --
TC DUPLICATION3	-- Please Select --	-- Please Select --
D/A INTERACTION1	-- Please Select --	-- Please Select --
D/A INTERACTION2	-- Please Select --	-- Please Select --
D/A INTERACTION3	-- Please Select --	-- Please Select --
IA DURATION1	-- Please Select --	-- Please Select --
IA DURATION2	-- Please Select --	-- Please Select --
IA DURATION3	-- Please Select --	-- Please Select --

	AHFS TC (Level 2)	AHFS TC
D/D INTERACTIONS1	-- Please Select --	-- Please Select --
D/D INTERACTIONS2	-- Please Select --	-- Please Select --
D/D INTERACTIONS3	-- Please Select --	-- Please Select --
D/Dis CONTRAINDICATION1	-- Please Select --	-- Please Select --
D/Dis CONTRAINDICATION2	-- Please Select --	-- Please Select --
D/Dis CONTRAINDICATION3	-- Please Select --	-- Please Select --
OTHER (specify)1	Central Nervous System Agents	Anticonvulsants
OTHER (specify)2	-- Please Select --	-- Please Select --
OTHER (specify)3	-- Please Select --	-- Please Select --
OTHER (specify)4	-- Please Select --	-- Please Select --
OTHER (specify)5	-- Please Select --	-- Please Select --
OTHER (specify)6	-- Please Select --	-- Please Select --
OTHER (specify)7	-- Please Select --	-- Please Select --
OTHER (specify)8	-- Please Select --	-- Please Select --
OTHER (specify)9	-- Please Select --	-- Please Select --

26. II-11. 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: *

N a) Medicaid agency

8 b) State Board of Pharmacy

N c) Other- please explain

27. II-12. 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

28. 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) ATT1-2014-AZ-POCCR *

File: ATT1-2014-NV-POCCR.docx

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CMS-R-153 (05/2017)

Please print a copy of this section for your records before clicking "NEXT" button.

Back Next

23%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 4

OMB approved#: 0938-0659

29. 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) *

Academic institution

30. Organization Name *

University of Mass

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

No

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

Yes

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

No

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

The DUR Board offers topics and reviews results, but does not approve before letters are sent.

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) ATT2-2014-AZ-REOS *

File: ATT2-2014-NV-REOS.xlsx

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CMS-R-153 (05/2017)

Please print a copy of this section for your records before clicking "NEXT" button.

Back Next

31%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 5

OMB approved#: 0938-0659

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) ATT3-2014-AZ-SDBA** *

File: ATT3-2014-NV-SDBA.docx

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

No

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

No

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CMS-R-153 (05/2017)

Please print a copy of this section for your records before clicking "NEXT" button.

Back Next

38%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 6

OMB approved#: 0938-0659

41. 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 both Prospective DUR and Retrospective DUR? *

No

42. If "No to V," do you have a plan to include this information in your DUR criteria in the future? *

Yes

CMS-R-153 (05/2017)

Please print a copy of this section for your records before clicking "NEXT" button.

Back Next

46%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 7

OMB approved#: 0938-0659

43. 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

44. 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) ATT4-2014-AZ-GDSP *

File: ATT4-2014-NV-GDSP.docx

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45. VI-2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your state have a more restrictive requirement? *

Yes

46. If "Yes" to VI-2 above, check all that apply: *

N a) Require that a MedWatch Form be submitted

N b) Require medical reason for override accompany prescription

8 c) Preauthorization is required

N d) Other – please explain

47. 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.

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 2014 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	539778	2192484	61047
Total Reimbursement Amount Less Co-Pay	17344077	41015654	3993037

48. 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 *

2192484

49. Total Number of claims *

2793309

50. Generic Utilization Percentage *

78%

51. 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 *

41015654

52. Total Dollars *

218449463

53. Generic Expenditure Percentage *

19%

CMS-R-153 (05/2017)

Please print a copy of this section for your records before clicking "NEXT" button.

Back Next

54%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 8

OMB approved#: 0938-0659

54. 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

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

Company

56. Organization Name to VII-2 *

Catamaran

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

	Data
ProDUR Total Estimated Avoided Costs *	92862113
RetroDUR Total Estimated Avoided Costs *	0
Other cost avoidance *	0
Grand Total estimated Avoided Costs *	92862113

58. 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 = *

42%

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

Yes

60. 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) ATT5-2014-AZ-CSCAM *

File: ATT5-2014-NV-CSCAM.docx

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CMS-R-153 (05/2017)

Please print a copy of this section for your records before clicking "NEXT" button.

Back Next

62%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 9

OMB approved#: 0938-0659

61. 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

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

N a. Deny claims and require pre-authorization

8 b. Refer to lock-in program

N c. Refer to Program Integrity Unit

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

63. If check to above is "d. Other," please explain *

Refer the recipient to Welfare for eligibility verification, refer to Board of Pharmacy, or the Program Integrity Unit.

64. VIII-A2. Do you have to a "lock-in" program? *

Yes

65. If “Yes”, what criteria does your state use to identify candidates for lock-in? Check all that apply. *

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

66. If "Yes", what is the usual "lock-in" time period? *

Other

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

Indefinite

68. If "yes" do you restrict the beneficiary to: *

i. a prescriber only: No
ii. a pharmacy only: Yes
iii. a prescriber and pharmacy: No

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

0.005%

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

129371

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

No

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

No

73. VIII B. PRESCRPTION DRUG MONITORING PROGRAM (PDMP)

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

Yes

74. If "Yes" does your agency have the ability to query the state's PDMP database? *

Yes

75. If "Yes" do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing restricted substances? *

No

If "Yes," please explain how the state applies this information to control fraud and abuse. *

Used for lock-in and monitoring reported cases from the community.

76. If "Yes" do you also have access to border states' PDMP information? *

No

77. 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? *

Yes

78. If "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) *

Limited access by select individuals, no access to contractors for State Services.

79. VIII C. Pain Management Controls

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

No

80. 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

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

No

82. VIII-C4. Do you have measures in place to monitor/manage the prescribing of methadone for pain management? If “yes” check all that apply:

N pharmacist override

N deny claim and require PA

N quantity limits

N intervention letters

83. VIII D. OPIOIDS

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

Yes

84. If "Yes" what are your limitations? *

30 day supply

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

Yes

86. If "Yes" what are your limitations? *

other, please explain

87. other, please explain *

Qty limits specific to product.

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

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

No

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

No

90. 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

91. VIII F. BUPRENORPHINE

VIII-F1. Does your agency set mg per day limits on the use of buprenorphine? *

Yes

92. If "Yes", please specify the total mg/day? *

16mg

93. VIII-F2. What are your limitations on the allowable length of treatment? *

no limit

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

No

95. VIII-F4. What are your limitations on the allowable length of treatment? *

no limit

96. VIII-F5. Do you limit the type of dosage form that can be dispensed to only the sublingual film? *

No

97. VIII G. PSYCHOTROPIC DRUGS/STIMULANTS

VIII-G1. Do you have a documented program in place to manage/monitor the appropriate use of psychotropic drugs in children? *

Yes

98. If "Yes", do you manage/monitor: *

all children

99. If "Yes", please briefly explain the specifics of your program(s). *

All require clinical prior authorization for psychiatric related medications. Foster children are reported monthly for psychiatric medications and diagnosis to state agency.

100. VIII-G2. Do you have any documented restrictions or special program in place to monitor/manage or control the use of stimulants? *

Yes

101. If "yes" is your program limited to : *

both

102. If "Yes", please briefly explain the specifics of your program(s). *

Prior authorization is required for children and adults. Both require a complete evaluation.

Back Next

85%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 10

103.

IX. INNOVATIVE PRACTICES

Have you developed any innovative practices during the past year which you have included in Attachment 6 - Innovative Practices ? *

No

Back Next

77%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 11

OMB approved#: 0938-0659

104. X. E-PRESCRIBING

X-1. Has your State implemented e-prescribing? *

Yes

If “Yes,” please respond to Questions X-2 and X-3 below.

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

Yes

106. X-3. Does your program system (MMIS or pharmacy vendor) have the capability to electronically provide a prescriber, upon inquiry, patient drug history data and pharmacy coverage limitations prior to prescribing? *

No

107. c) If 'No', are you planning to develop this capability? *

Yes

CMS-R-153 (05/2017)

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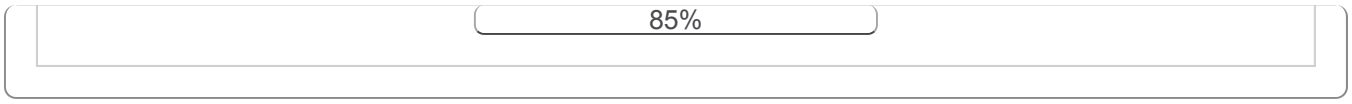
Back Next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FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 12

OMB approved#: 0938-0659

108. XI. MANAGED CARE ORGANIZATIONS (MCOs)

XI-1. Is your pharmacy program included in the capitation rate (carved-in) *

Yes

109. XI-2. Does the state set requirements for the MCO's pharmacy benefit? *

No

110. If "No" do you plan to set standard in the future? *

No

111. XI-3. Does the state require the MCOs to monitor or report their DUR activities? *

No

112. If "no" do you plan to develop a program to monitor or report MCO DUR activities in the future? *

No

CMS-R-153 (05/2017)

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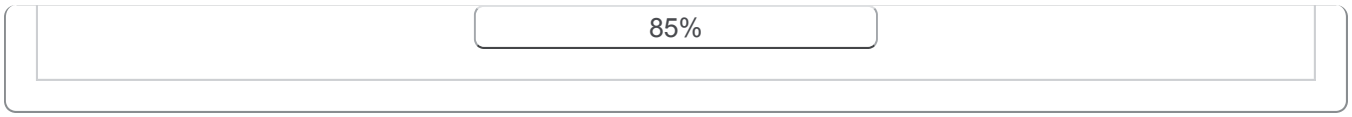
Back Next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FFY 2014 Medicaid Drug Utilization Review Annual Report

Page 13

OMB approved#: 0938-0659

113. 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) ATT8-2014-AZ-ES *

File: ATT8-2014-NV-ES.docx

CMS-R-153 (05/2017)

Please review report for accuracy and print a copy of report for your records before clicking "SUBMIT" button.

Back Submit

92%

FFY 2014 Medicaid Drug Utilization Review Annual Report

Thank you for completing this survey.

This is your confirmation that your survey has been successfully submitted.

Please print a copy of this page and keep it with a copy of your report.

100%

FFY 2014
Nevada Medicaid

Attachment 1: Pharmacy Oral Counseling Compliance Report

The State of Nevada Medicaid Program relies on the State Board of Pharmacy to audit pharmacist compliance with the oral counseling requirement. The Nevada State Board of Pharmacy includes adherence with counseling requirements as part of each annual pharmacy inspection. In addition, during any investigation of an incident or patient complaint, counseling records are checked by the inspector.

Profile Cycle Month/Year	Number of Profiles Reviewed	Number of Profiles Produced	Number of Profiles Selected for Interventions	Number of Letters to Providers for Interventions	Number of Letters to Pharmacies for Interventions
October 2013					
November 2013	24		24	24	
December 2013	810		921	921	0
January 2014					
February 2014					
March 2014					
April 2014					
May 2014	100		100	100	0
June 2014					
July 2014					
August 2014					
September 2014					
Total	**934**	**0**	**1045**	**1045**	**0**

Month Reviewed	RetroDUR Intervention Topic
November 2013	Migraine prophylaxis
December 2013	Zolpidem dosing for insomnia
May 2014	Atypical Antipsychotics in Pediatric Patients

Number of Responses	% of Responses	Criteria Interventions				
		Insufficient Dose	Drug/Drug Interaction	Incorrect Duration	Drug/Disease Contraindication	Over Utilization
	#DIV/0!					
5	21%					
543	59%					X
	#DIV/0!					
	#DIV/0!					
	#DIV/0!					
	#DIV/0!					
0	0%					X
	#DIV/0!					
	#DIV/0!					
	#DIV/0!					
	#DIV/0!					
548	**#DIV/0!**	**0**	**0**	**0**	**0**	**0**

Therapeutic Duplication	Under Utilization	Appropriate Use of Generics
	X	
0	0	0

FFY 2014

Nevada Medicaid

Attachment 3 – Summary of Drug Use Review Board Activities

In FFY 2014, the Drug Use Review Board held three regular meetings, on January 23, 2014, April 24, 2014 and July 24, 2014, and one special meeting on August 13, 2014.

Meeting Minutes Summary:

January 23, 2014

- Reviewed utilization for products used to treat homozygous familial hypercholesterolemia (HoFH).
- Reviewed utilization and adopted clinical criteria for the use of ibuprofen/famotidine combination.
- Reviewed utilization and adopted updated criteria for immunomodulators.
- Reviewed utilization for long and short-acting opioids
- Reviewed utilization and adopted updated criteria for platelet inhibitors
- Reviewed utilization and adopted quantity limits for promethazine with codeine syrup
- Discussed utilization of psychotropics in children.
- Retro-DUR activities and responses discussed

April 24, 2014

- Reviewed utilization and adopted clinical prior authorization criteria for sofosbuvir
- Reviewed utilization and adopted updated clinical prior authorization criteria for protease inhibitors for the treatment of hepatitis C.
- Reviewed utilization and adopted updated clinical prior authorization criteria for medications use to treat ADD/ADHD.
- Reviewed utilization and adopted updated clinical prior authorization criteria with quantity limits for buprenorphine and buprenorphine/naloxone products
- Reviewed utilization and adopted quantity limits for Zohydro ER.
- Reviewed utilization and trends for the following: Controlled substances, psychotropics in children, promethazine VC, blood factor products, and aripiprazole by age and diagnosis
- Reviewed ProDUR responses for late refills in general and specifically for medications used to treat seizure disorders.

July 24, 2014

- Reviewed utilization and adopted updated clinical criteria for omalizumab
- Reviewed utilization and adopted updated clinical criteria for ivacaftor
- Reviewed utilization and trends for the following: Black box warning drugs, controlled substances, psychotropic use in children, buprenorphine and buprenorphine/naloxone

- Reviewed ProDUR late refill edits and a correlation to Emergency Room visits.
- Retro-DUR activities and responses discussed.

August 13, 2014 – Special Meeting

- Reviewed utilization and adopted updated clinical criteria for palivizumab

FFY 2014
Nevada Medicaid

Attachment 4: Generic Drug Substitution Policies

The Nevada Statute NRS 639.2583 requires that if a practitioner has prescribed a drug by brand name and the practitioner has not indicated that a substitution is prohibited, the pharmacist who fills or refills the prescription shall dispense, in substitution, another drug which is available to him or her if the other drug is a) less expensive than the drug prescribed by brand name; b) is biologically equivalent to the drug prescribed by brand name; c) has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the drug prescribed by brand name; and d) is of the same generic type as the drug prescribed by brand name. If the pharmacist has available to him or her more than one drug that may be substituted for the drug prescribed by brand name, the pharmacist shall dispense, in substitution, the least expensive of the drugs that are available to him or her for substitution. Before a pharmacist dispenses a drug in substitution for a drug prescribed by brand name, the pharmacist shall: a) advise the person who presents the prescription that the pharmacist intends to dispense a drug in substitution; and b) advise the person that he or she may refuse to accept the drug that the pharmacist intends to dispense in substitution, unless the pharmacist is being paid for the drug by a governmental agency. If a person refuses to accept the drug that the pharmacist intends to dispense in substitution, the pharmacist shall dispense the drug prescribed by brand name, unless the pharmacist is being paid for the drug by a governmental agency, in which case the pharmacist shall dispense the drug in substitution.

FFY 2014

Nevada Medicaid

Attachment 5: Cost Savings/Cost Avoidance Methodology

Catamaran calculates the ProDUR savings by summing the amounts on claims either reversed or denied due to a ProDUR edit. We understand these numbers will be inflated as there is no way to track if the medication was later filled again after consulting with the prescriber or patient, or taken to a different pharmacy. Below is the summary by types ProDUR edits.

Conflict Code	Sum of Total DUR Savings	
COMPLIAN	$	3,613,135.09
DDI-DTMS	$	7,334,705.84
DOSECHEK	$	19,288,034.49
DRUG_AGE	$	202.01
DRUG_SEX	$	-
DUPRX	$	20,550,916.06
DUPTHER	$	34,082,884.17
TOO SOON	$	7,992,235.58
Grand Total	**$**	**92,862,113.24**

FFY 2014

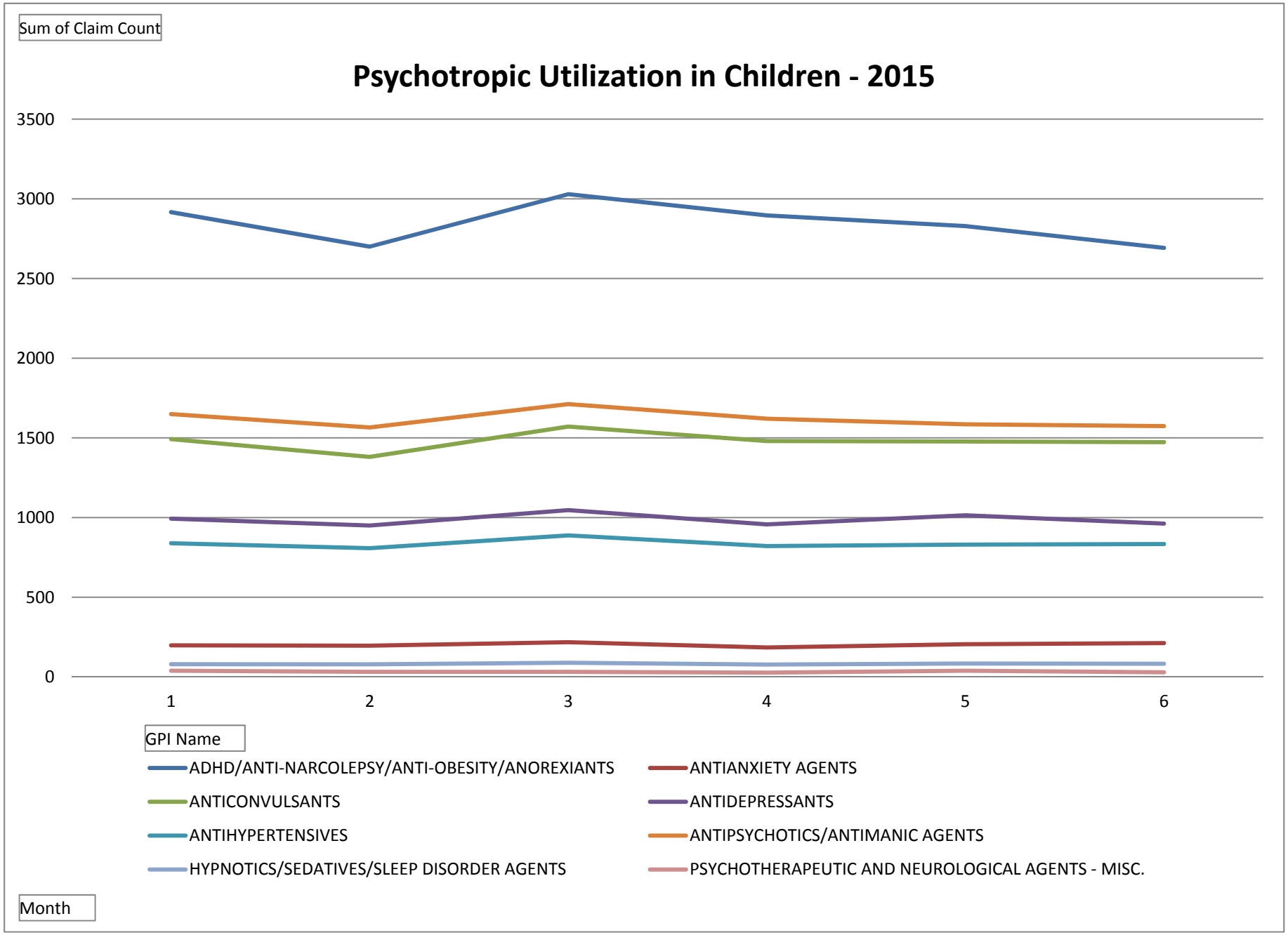
Nevada Medicaid

Attachment 8: Executive Summary

The Nevada Medicaid Drug Utilization Review (DUR) Board serves in an advisory role for the Division of Health Care Financing and Policy (DHCFP) for the development and maintenance of Nevada Medicaid's Medicaid Service Manual (MSM) Chapter 1200 – Prescribed Drugs. MSM Chapter 1200 defines policy for drug coverage, restrictions, prior authorizations and exclusions.

The DUR Board currently is comprised of three physicians and three pharmacists from various backgrounds and locations around the State of Nevada. Other non-voting members who contribute to Board discussions include employees from DHCFP, a Deputy Attorney General and representatives from the contractors for MMIS and PBM services. The public is welcome to provide testimony to the board before they vote on topics.

Clinical reviews and proposed prior authorization criteria for the Board are supplied by Clinical Pharmacy Services, associated with the University of Massachusetts. Additional input is provided by pharmaceutical manufactures, members of the public and the DUR Boards unique experiences and research.


Sum of Claim Count
Psychotropic Utilization in Children - 2015
3500
3000
2500
2000
1500
1000
500
0
1
2
3
4
5
6
GPI Name
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
ANTIANXIETY AGENTS
ANTICONVULSANTS
ANTIDEPRESSANTS
ANTIHYPERTENSIVES
ANTIPSYCHOTICS/ANTIMANIC AGENTS
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
Month

Psychotropic Utilization

January 1, 2015 - June 30, 2015

Age 0-5

Drug Class - Month	Sum of Claim Count
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	393
1	65
2	73
3	61
4	65
5	60
6	69
ANTIANXIETY AGENTS	129
1	20
2	17
3	23
4	21
5	18
6	30
ANTICONVULSANTS	1,230
1	211
2	196
3	206
4	207
5	196
6	214
ANTIDEPRESSANTS	58
1	7
2	8
3	10
4	12
5	10
6	11
ANTIHYPERTENSIVES	415
1	74
2	65
3	72
4	65
5	69
6	70
ANTIPSYCHOTICS/ANTIMANIC AGENTS	230
1	47
2	41
3	32
4	40
5	32
6	38
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS	243
1	40
2	38
3	45
4	39
5	41
6	40
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	5
1	1
3	1
4	1
5	1
6	1
Grand Total	**2,703**

Psychotropic Utilization

January 1, 2015 - June 30, 2015

Age 13-17

Drug Class - Month	Sum of Claim Count
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	**5,365**
1	914
2	809
3	963
4	919
5	910
6	850
ANTIANXIETY AGENTS	**638**
1	103
2	105
3	109
4	102
5	114
6	105
ANTICONVULSANTS	**3,733**
1	611
2	577
3	682
4	618
5	624
6	621
ANTIDEPRESSANTS	**3,832**
1	646
2	601
3	696
4	597
5	669
6	623
ANTIHYPERTENSIVES	**1,557**
1	266
2	229
3	287
4	258
5	255
6	262
ANTIPSYCHOTICS/ANTIMANIC AGENTS	**4,597**
1	768
2	709
3	818
4	775
5	767
6	760
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS	**111**
1	21
2	18
3	19
4	19
5	17
6	17
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	**74**
1	13
2	13
3	10
4	12
5	14
6	12
Grand Total	**19,907**

Psychotropic Utilization

January 1, 2015 - June 30, 2015

Age 6-12

Drug Class - Month	Sum of Claim Count
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	11,304
1	1,937
2	1,818
3	2,005
4	1,912
5	1,859
6	1,773
ANTIANXIETY AGENTS	447
1	75
2	74
3	86
4	62
5	73
6	77
ANTICONVULSANTS	3,911
1	670
2	608
3	683
4	655
5	657
6	638
ANTIDEPRESSANTS	2,033
1	340
2	341
3	341
4	348
5	335
6	328
ANTIHYPERTENSIVES	3,048
1	499
2	514
3	529
4	498
5	506
6	502
ANTIPSYCHOTICS/ANTIMANIC AGENTS	4,878
1	834
2	815
3	862
4	805
5	786
6	776
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS	139
1	19
2	23
3	25
4	20
5	26
6	26
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	119
1	25
2	19
3	21
4	14
5	24
6	16
Grand Total	**25,879**

Lock-In Savings Report July 2015

Note	Summary					
Summary calculations do not take into account the claims and amounts for inactive members.	Active Recipients	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
	647	7,510	$578,167.13	5,336	$598,751.30	$ (20,584.17)

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
1	11/1/2008	12/1/2008	12/31/2039	A	18	1524.88			1524.88
2	11/1/2008	12/1/2008	11/30/2009	I	2	9.59			
3	11/1/2008	12/1/2008	12/31/2039	A	5	86.8	15	342.5899	-255.7899
4	2/1/2009	3/1/2009	10/26/2009	I	9	184.93			
5	2/1/2009	3/1/2009	6/30/2015	I	0	0			
6	2/1/2009	3/1/2009	6/30/2010	I	26	731.87			
7	3/1/2009	4/1/2009	6/30/2015	I	23	349.2			
8	5/1/2009	6/1/2009	9/30/2009	I	10	1957.14			
9	5/1/2009	6/1/2009	7/31/2010	I	25	679.96			
10	5/1/2009	6/1/2009	9/30/2010	I	23	781.46			
11	6/1/2009	7/1/2009	7/31/2009	I	65	13169.84			
12	6/8/2009	7/8/2009	12/31/2039	A	9	706.37	15	2538.81	-1832.44
13	8/16/2009	9/16/2009	12/31/2039	A	1	11.3699			11.3699
14	8/25/2009	9/25/2009	12/31/2039	A	8	970.5	12	982.87	-12.37
15	10/1/2009	11/1/2009	12/31/2039	A	4	9.3	6	9.6	-0.3
16	12/1/2009	1/1/2010	12/31/2039	A	6	401.17	9	188.68	212.49
17	12/1/2009	1/1/2010	12/31/2039	A	0	0	14	160.73	-160.73
18	4/11/2010	5/11/2010	12/31/2039	A	9	453.07	17	288.66	164.41
19	8/1/2010	9/1/2010	9/16/2010	I	4	71.93			
20	8/1/2010	9/1/2010	12/31/2039	A	15	196.99	9	764.55	-567.56
21	8/1/2010	9/1/2010	5/31/2011	I	23	224.79			
22	8/20/2010	9/20/2010	12/31/2039	A	15	2669.44	9	1241.44	1428
23	10/1/2010	11/1/2010	12/31/2039	A	6	681.86			681.86
24	10/1/2010	11/1/2010	12/31/2039	A	15	2089.34	4	14.86	2074.48
25	1/1/2011	2/1/2011	9/25/2012	I	27	3042.05			

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
26	1/1/2011	2/1/2011	12/31/2039	A	9	430.85	7	425.61	5.24
27	1/1/2011	2/1/2011	8/31/2011	I	4	143.27			
28	1/1/2011	2/1/2011	3/7/2015	I	12	1326.33			
29	3/12/2011	4/12/2011	9/30/2014	I	4	694.27			
30	3/12/2011	4/12/2011	12/31/2039	A	5	472.05	6	132.52	339.53
31	4/1/2011	5/1/2011	12/31/2039	A	10	48.6	6	86.0699	-37.4699
32	4/1/2011	5/1/2011	1/6/2014	I	7	82.03			
33	4/1/2011	5/1/2011	12/31/2039	A	11	251.96	15	291.72	-39.76
34	4/1/2011	5/1/2011	12/31/2039	A	18	2792.09	18	946.08	1846.01
35	4/1/2011	5/1/2011	4/30/2011	I	0	0			
36	7/1/2011	8/1/2011	12/31/2039	A	41	1032.27	22	957.37	74.9
37	8/1/2011	9/1/2011	12/31/2039	A	0	0			0
38	8/1/2011	9/1/2011	12/31/2039	A	14	204.5	1	9.38	195.12
39	8/1/2011	9/1/2011	12/31/2039	A	26	1030.75	10	574.65	456.1
40	8/1/2011	9/1/2011	12/31/2039	A	0	0			0
41	8/1/2011	9/1/2011	7/26/2014	I	29	433.62			
42	8/1/2011	9/1/2011	10/31/2012	I	0	0			
43	8/1/2011	9/1/2011	3/9/2013	I	17	580.8			
44	8/1/2011	9/1/2011	12/31/2039	A	4	75.51			75.51
45	10/16/2011	11/16/2011	12/31/2039	A	1	10.1199			10.1199
46	11/1/2011	12/1/2011	6/30/2015	I	3	22.4			
47	11/1/2011	12/1/2011	12/31/2039	A	13	605.91	15	998.03	-392.12
48	11/1/2011	12/1/2011	12/31/2039	A	10	119.99			119.99
49	11/1/2011	12/1/2011	8/31/2012	I	6	75.29			
50	11/1/2011	12/1/2011	12/31/2039	A	16	625.59	8	32687.36	-32061.77
51	11/1/2011	12/1/2011	12/31/2039	A	5	205.4199	1	6.1	199.3199
52	11/1/2011	12/1/2011	12/31/2039	A	10	181.48	38	329.05	-147.57
53	11/1/2011	12/1/2011	12/31/2039	A	12	302.1			302.1
54	11/1/2011	12/1/2011	12/31/2039	A	27	7985.99	12	306.41	7679.58
55	11/1/2011	12/1/2011	12/31/2039	A	16	375.51	24	1071.46	-695.95
56	11/1/2011	12/1/2011	12/31/2039	A	13	1105.44	1	111.38	994.06
57	11/1/2011	12/1/2011	1/29/2013	I	16	907.35			
58	11/1/2011	12/1/2011	12/31/2039	A	13	390.26	2	83.27	306.99
59	11/1/2011	12/1/2011	12/31/2039	A	11	151.56	5	375.44	-223.88
60	11/1/2011	12/1/2011	7/2/2014	I	8	265.54			
61	11/1/2011	12/1/2011	12/31/2039	A	1	4	13	691.95	-687.95
62	11/1/2011	12/1/2011	12/31/2039	A	12	609.23	9	751.69	-142.46
63	11/1/2011	12/1/2011	12/31/2039	A	7	333.3399			333.3399
64	11/1/2011	12/1/2011	12/31/2039	A	24	1304.94	25	1656.31	-351.37
65	11/1/2011	12/1/2011	4/20/2013	I	10	327.22			

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
66	11/1/2011	12/1/2011	2/19/2012	I	0	0			
67	11/1/2011	12/1/2011	1/17/2015	I	4	47.02			
68	11/1/2011	12/1/2011	12/31/2039	A	15	558.62	13	1229.1	-670.48
69	11/1/2011	12/1/2011	12/31/2039	A	7	164.98	15	813.97	-648.99
70	11/1/2011	12/1/2011	7/31/2015	I	19	415.81	1	1.88	
71	11/1/2011	12/1/2011	5/3/2012	I	5	539.92			
72	12/5/2011	1/5/2012	12/31/2039	A					0
73	1/1/2012	2/1/2012	11/8/2012	I	15	300.3399			
74	1/20/2012	2/20/2012	12/31/2039	A	8	1610.07			1610.07
75	1/20/2012	2/20/2012	12/31/2039	A	7	300.11	4	262.01	38.1
76	3/1/2012	4/1/2012	12/31/2039	A	8	320.0899	8	761.09	-441.0001
77	3/1/2012	4/1/2012	12/31/2039	A	31	210.93	11	697.25	-486.32
78	3/1/2012	4/1/2012	12/31/2039	A	23	883.87	15	1003.28	-119.41
79	3/1/2012	4/1/2012	12/31/2039	A	6	299.61	6	176.49	123.12
80	3/1/2012	4/1/2012	12/31/2039	A	14	638.97	9	649.87	-10.9
81	3/1/2012	4/1/2012	12/31/2039	A	19	5855.6	1	126.88	5728.72
82	3/1/2012	4/1/2012	12/31/2039	A	26	159.7	21	685.58	-525.88
83	3/1/2012	4/1/2012	11/30/2014	I	24	145.4			
84	3/1/2012	4/1/2012	12/31/2039	A	17	642.6	16	1089.89	-447.29
85	3/1/2012	4/1/2012	12/31/2039	A	16	664.28	30	742.38	-78.1
86	3/1/2012	4/1/2012	2/6/2014	I	26	1018.72			
87	4/1/2012	5/1/2012	7/31/2013	I	11	866.8			
88	4/1/2012	5/1/2012	12/31/2039	A	8	3686.76	24	6586.04	-2899.28
89	4/1/2012	5/1/2012	12/31/2039	A	6	1307.35	8	950.49	356.86
90	4/1/2012	5/1/2012	12/31/2039	A	23	866.26	21	1650.52	-784.26
91	4/1/2012	5/1/2012	12/31/2039	A	23	258.66	7	419.96	-161.3
92	4/1/2012	5/1/2012	12/31/2039	A	2	37.75	5	250.28	-212.53
93	4/1/2012	5/1/2012	12/31/2039	A	7	747.4299			747.4299
94	4/1/2012	5/1/2012	9/1/2014	I	8	618.5			
95	4/1/2012	5/1/2012	12/31/2039	A	0	0			0
96	4/1/2012	5/1/2012	12/31/2039	A	20	1791.18	11	2220.59	-429.41
97	4/1/2012	5/1/2012	12/31/2039	A	14	1424.2	37	2646.56	-1222.36
98	4/1/2012	5/1/2012	12/31/2039	A	21	853.3	11	372.63	480.67
99	4/1/2012	5/1/2012	12/31/2039	A	18	755.82	12	22.72	733.1
100	4/1/2012	5/1/2012	12/31/2039	A	5	144.32	12	747.8099	-603.4899
101	4/1/2012	5/1/2012	12/31/2039	A	9	233.34	6	267.79	-34.45
102	4/1/2012	5/1/2012	6/30/2015	I	13	638.3099			
103	4/1/2012	5/1/2012	12/31/2039	A	6	184.37			184.37
104	4/1/2012	5/1/2012	12/31/2039	A	10	425.87			425.87
105	4/1/2012	5/1/2012	12/31/2039	A	14	584.1	5	143.5	440.6

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
106	5/1/2012	6/1/2012	12/31/2039	A	8	1031.81	4	182.6699	849.1401
107	5/1/2012	6/1/2012	12/31/2039	A	7	205.34	24	3795.45	-3590.11
108	5/1/2012	6/1/2012	1/31/2013	I	7	301.38			
109	5/1/2012	6/1/2012	12/31/2039	A	34	1408.98			1408.98
110	5/1/2012	6/1/2012	5/31/2015	I	20	21.68			
111	5/1/2012	6/1/2012	12/31/2039	A	12	222.75	5	528.72	-305.97
112	5/1/2012	6/1/2012	9/14/2014	I	12	540.97			
113	5/1/2012	6/1/2012	12/31/2039	A	1	67.86	13	2182.42	-2114.56
114	5/1/2012	6/1/2012	12/31/2039	A	11	359.15	12	1271.42	-912.27
115	5/1/2012	6/1/2012	12/31/2039	A	8	910.77	9	5938.89	-5028.12
116	5/1/2012	6/1/2012	12/31/2039	A	8	2463.03	4	42	2421.03
117	5/1/2012	6/1/2012	7/31/2014	I	9	283.48			
118	5/1/2012	6/1/2012	12/31/2039	A	10	1042.97			1042.97
119	5/1/2012	6/1/2012	6/30/2015	I	10	1362.2			
120	5/1/2012	6/1/2012	12/31/2039	A	16	516.5	15	250.59	265.91
121	5/1/2012	6/1/2012	12/31/2039	A	30	1351.06	11	395.33	955.73
122	5/1/2012	6/1/2012	3/31/2015	I	16	1665.82			
123	5/1/2012	6/1/2012	6/19/2015	I	10	1451.58			
124	5/1/2012	6/1/2012	8/31/2013	I	14	218.98			
125	5/1/2012	6/1/2012	12/31/2039	A	15	882.14	11	394.36	487.78
126	5/1/2012	6/1/2012	12/31/2039	A	5	153.46	5	366.4	-212.94
127	5/1/2012	6/1/2012	12/31/2039	A	9	531.3099	11	1660.73	-1129.4201
128	5/1/2012	6/1/2012	4/18/2015	I	21	350			
129	5/1/2012	6/1/2012	12/31/2039	A	3	127.49	9	666.32	-538.83
130	5/1/2012	6/1/2012	12/31/2039	A	4	152.32			152.32
131	5/1/2012	6/1/2012	12/31/2039	A	5	140.73	4	334.48	-193.75
132	5/1/2012	6/1/2012	12/31/2039	A	5	202.1399	8	330.22	-128.0801
133	5/1/2012	6/1/2012	12/31/2039	A	7	286.5			286.5
134	5/1/2012	6/1/2012	3/31/2013	I	9	504.26			
135	5/1/2012	6/1/2012	12/31/2039	A	5	195.3899	10	925.81	-730.4201
136	5/1/2012	6/1/2012	12/31/2039	A	12	3276.94	3	194.78	3082.16
137	5/1/2012	6/1/2012	6/30/2013	I	7	332.43			
138	5/1/2012	6/1/2012	12/31/2039	A	8	114.68	5	86.4599	28.2201
139	5/1/2012	6/1/2012	12/31/2012	I	10	561.71			
140	5/1/2012	6/1/2012	12/31/2039	A	13	1365.47	11	2277.55	-912.08
141	5/1/2012	6/1/2012	12/31/2039	A	59	2978.4699	8	108.84	2869.6299
142	5/1/2012	6/1/2012	12/31/2039	A	12	413.73	2	2.4	411.33
143	5/1/2012	6/1/2012	12/31/2039	A	14	642.78	3	82.44	560.34
144	5/1/2012	6/1/2012	12/31/2039	A	3	65.94	3	129.76	-63.82
145	5/1/2012	6/1/2012	12/31/2039	A	14	348.11			348.11

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
146	5/1/2012	6/1/2012	12/31/2039	A	10	198.22	10	2043.12	-1844.9
147	5/1/2012	6/1/2012	12/31/2039	A	15	826.82			826.82
148	5/1/2012	6/1/2012	11/30/2014	I	2	43.1			
149	5/1/2012	6/1/2012	12/31/2039	A	19	2805.57	17	1306.6099	1498.9601
150	5/1/2012	6/1/2012	12/31/2039	A	6	193.4199	9	1863.31	-1669.8901
151	5/1/2012	6/1/2012	12/31/2039	A	9	102.72	6	81.48	21.24
152	5/1/2012	6/1/2012	12/31/2039	A	9	149.94	5	220.87	-70.93
153	5/1/2012	6/1/2012	9/30/2012	I	7	15.36			
154	5/1/2012	6/1/2012	12/31/2039	A	4	1204.34	8	720.71	483.63
155	6/1/2012	7/1/2012	8/19/2013	I	14	598.99			
156	6/1/2012	7/1/2012	2/1/2015	I	19	288.68			
157	7/1/2012	8/1/2012	12/31/2039	A	30	2380.14	7	462.98	1917.16
158	7/1/2012	8/1/2012	12/31/2039	A	4	125	2	16.32	108.68
159	7/1/2012	8/1/2012	12/31/2039	A	12	644.4			644.4
160	7/1/2012	8/1/2012	12/31/2039	A	7	93.34	4	93.89	-0.55
161	7/1/2012	8/1/2012	12/31/2039	A	8	198.25	8	2026.76	-1828.51
162	7/1/2012	8/1/2012	8/31/2014	I	13	1492.81			
163	7/1/2012	8/1/2012	12/31/2039	A	8	165.56	9	329.93	-164.37
164	7/1/2012	8/1/2012	12/31/2039	A	8	36.47	7	13.2	23.27
165	7/1/2012	8/1/2012	10/25/2014	I	4	82.0699			
166	7/1/2012	8/1/2012	7/31/2013	I	6	14.84			
167	7/1/2012	8/1/2012	7/31/2015	I	16	686.86	8	232.77	
168	7/1/2012	8/1/2012	12/31/2039	A	10	2117.08			2117.08
169	7/1/2012	8/1/2012	12/31/2039	A	15	1074.91	17	1135.74	-60.83
170	7/1/2012	8/1/2012	12/31/2039	A	14	153.13	9	949.31	-796.18
171	7/1/2012	8/1/2012	12/31/2039	A	6	73.73			73.73
172	7/1/2012	8/1/2012	7/20/2013	I	4	105.15			
173	7/1/2012	8/1/2012	12/31/2039	A	10	118.94	12	586.23	-467.29
174	7/1/2012	8/1/2012	5/31/2015	I	11	806.78			
175	7/1/2012	8/1/2012	12/31/2039	A	9	1634.49	6	1036.51	597.98
176	7/1/2012	8/1/2012	12/31/2039	A	5	133.85	4	2.16	131.69
177	7/1/2012	8/1/2012	7/31/2013	I	9	1993.36			
178	7/1/2012	8/1/2012	12/31/2039	A	14	1576.6099	8	1445.8699	130.74
179	7/1/2012	8/1/2012	8/31/2015	A	3	56.78			56.78
180	7/1/2012	8/1/2012	10/31/2012	I	9	22.67			
181	7/1/2012	8/1/2012	7/31/2013	I	3	2.65			
182	7/1/2012	8/1/2012	12/31/2012	I	15	290.24			
183	7/1/2012	8/1/2012	12/31/2039	A	0	0	9	1463.83	-1463.83
184	7/1/2012	8/1/2012	12/31/2039	A	9	1012.06	5	1724.1	-712.04
185	7/1/2012	8/1/2012	12/31/2039	A	8	125.87	6	242.11	-116.24

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
186	7/1/2012	8/1/2012	8/31/2015	A	6	136.18	6	103.05	33.13
187	7/1/2012	8/1/2012	8/31/2013	I	14	554.14			
188	7/1/2012	8/1/2012	12/31/2039	A	14	798.71	21	561.44	237.27
189	7/1/2012	8/1/2012	12/31/2039	A	10	443.93	6	89.42	354.51
190	7/1/2012	8/1/2012	4/24/2013	I	25	292.26			
191	7/1/2012	8/1/2012	12/31/2039	A	26	1350.13	22	1808.16	-458.03
192	7/1/2012	8/1/2012	7/9/2015	I	2	33.5			
193	7/1/2012	8/1/2012	12/31/2039	A	9	551.26	5	719.38	-168.12
194	7/1/2012	8/1/2012	11/30/2013	I	56	324.76			
195	7/1/2012	8/1/2012	12/31/2039	A	10	19.75	10	56.28	-36.53
196	7/1/2012	8/1/2012	12/31/2039	A	12	274.18	15	167.46	106.72
197	7/1/2012	8/1/2012	12/31/2039	A	5	722.57	17	1498.1	-775.53
198	7/1/2012	8/1/2012	10/31/2014	I	14	475.15			
199	7/1/2012	8/1/2012	12/31/2039	A	16	4124.42			4124.42
200	7/1/2012	8/1/2012	7/31/2015	I	6	26.36			
201	7/1/2012	8/1/2012	1/31/2013	I	21	1437.2			
202	7/1/2012	8/1/2012	10/31/2014	I	13	136.49			
203	7/1/2012	8/1/2012	12/31/2039	A	9	236.16	14	967.45	-731.29
204	7/1/2012	8/1/2012	12/31/2039	A	11	378.44	15	1371.33	-992.89
205	7/1/2012	8/1/2012	12/31/2039	A	6	135.1699			135.1699
206	7/1/2012	8/1/2012	12/31/2039	A	12	532.9299	14	234.41	298.5199
207	7/1/2012	8/1/2012	12/31/2039	A	3	56.23	9	1070.66	-1014.43
208	7/1/2012	8/1/2012	12/31/2039	A	10	101.49	2	67.12	34.37
209	7/1/2012	8/1/2012	12/31/2039	A	6	79.27	7	539.2	-459.93
210	7/1/2012	8/1/2012	11/30/2012	I	16	638.48			
211	7/1/2012	8/1/2012	3/21/2013	I	9	232.15			
212	7/1/2012	8/1/2012	12/31/2039	A	5	118.95	6	292.7	-173.75
213	7/1/2012	8/1/2012	12/31/2039	A	25	6821.19	14	523.73	6297.46
214	7/1/2012	8/1/2012	12/31/2039	A	11	518.59	9	369.0899	149.5001
215	7/1/2012	8/1/2012	12/31/2039	A	14	1496.48	14	77.72	1418.76
216	7/1/2012	8/1/2012	12/31/2039	A	16	1265.94	19	448.95	816.99
217	7/1/2012	8/1/2012	12/31/2039	A	13	32.54	13	218.19	-185.65
218	7/1/2012	8/1/2012	12/31/2039	A	13	2688.27			2688.27
219	7/1/2012	8/1/2012	12/31/2039	A	9	25.38	8	12	13.38
220	7/1/2012	8/1/2012	10/27/2013	I	13	98.78			
221	7/1/2012	8/1/2012	7/31/2015	I	8	374.66	7	225.81	
222	7/1/2012	8/1/2012	8/31/2014	I	10	378.63			
223	7/1/2012	8/1/2012	12/31/2039	A	14	62.57	12	71.24	-8.67
224	7/1/2012	8/1/2012	4/30/2013	I	13	593.98			
225	7/1/2012	8/1/2012	12/31/2039	A	11	32.79	1	6.25	26.54

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
226	7/1/2012	8/1/2012	12/31/2039	A	14	1804.98	9	1631.82	173.16
227	7/1/2012	8/1/2012	12/31/2039	A	12	440.41	3	40.22	400.19
228	7/1/2012	8/1/2012	5/21/2014	I	9	205.62			
229	7/1/2012	8/1/2012	12/31/2039	A	6	138.51	5	93.58	44.93
230	8/1/2012	9/1/2012	12/31/2039	A	12	1072.38	2	21.64	1050.74
231	8/1/2012	9/1/2012	12/31/2039	A	36	1080.41	28	2342.87	-1262.46
232	8/1/2012	9/1/2012	12/31/2039	A	4	154.04			154.04
233	8/1/2012	9/1/2012	12/31/2039	A	11	118.07			118.07
234	8/1/2012	9/1/2012	12/31/2039	A	5	91.36	6	112.26	-20.9
235	8/1/2012	9/1/2012	12/31/2039	A	5	9.73			9.73
236	8/1/2012	9/1/2012	12/31/2039	A	12	197.35	7	726.51	-529.16
237	8/1/2012	9/1/2012	12/31/2039	A	23	1937.33	8	1141.49	795.84
238	8/1/2012	9/1/2012	12/31/2039	A	4	110.76	5	78.74	32.02
239	8/1/2012	9/1/2012	12/31/2039	A	6	113.18			113.18
240	8/1/2012	9/1/2012	12/31/2039	A	18	1264.78	6	241.82	1022.96
241	8/1/2012	9/1/2012	2/28/2014	I	11	99.23			
242	8/1/2012	9/1/2012	12/31/2039	A	5	154.53	4	509.2	-354.67
243	8/1/2012	9/1/2012	12/31/2039	A	2	58.25	2	22.12	36.13
244	8/1/2012	9/1/2012	12/31/2039	A	7	500.31	13	2613.66	-2113.35
245	8/1/2012	9/1/2012	12/31/2039	A	12	238.77	3	37.52	201.25
246	8/1/2012	9/1/2012	12/31/2039	A	4	147.61			147.61
247	8/1/2012	9/1/2012	12/31/2039	A	8	419.06	7	20.92	398.14
248	8/1/2012	9/1/2012	12/31/2039	A	6	59.52	26	925.08	-865.56
249	8/1/2012	9/1/2012	7/31/2014	I	6	300.86			
250	8/1/2012	9/1/2012	12/31/2039	A	9	664.3	9	74.7099	589.5901
251	8/1/2012	9/1/2012	12/31/2039	A	5	143.85			143.85
252	8/1/2012	9/1/2012	12/31/2039	A	8	148.8	14	820.86	-672.06
253	8/1/2012	9/1/2012	12/31/2039	A	8	216.34	7	588.22	-371.88
254	8/1/2012	9/1/2012	12/31/2039	A	6	108.23			108.23
255	8/1/2012	9/1/2012	12/31/2039	A	18	849.3	2	585.87	263.43
256	8/1/2012	9/1/2012	12/31/2039	A	4	109.79	8	97.25	12.54
257	8/1/2012	9/1/2012	6/1/2013	I	8	139.1399			
258	8/1/2012	9/1/2012	9/4/2013	I					
259	8/1/2012	9/1/2012	12/31/2039	A	8	180.1	9	320.81	-140.71
260	8/1/2012	9/1/2012	12/31/2039	A	8	1638.79	6	1572.91	65.88
261	8/1/2012	9/1/2012	12/31/2039	A	10	26.74	7	469.77	-443.03
262	8/1/2012	9/1/2012	12/31/2039	A	9	3180.55	9	647.66	2532.89
263	8/1/2012	9/1/2012	12/31/2039	A	7	156.06	7	124.72	31.34
264	8/1/2012	9/1/2012	6/30/2015	I	8	6925.79			
265	8/1/2012	9/1/2012	12/31/2039	A	6	283.3399	3	9.27	274.0699

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
266	8/1/2012	9/1/2012	10/31/2014	I	22	456.81			
267	8/1/2012	9/1/2012	12/31/2039	A	22	771.09	7	131.76	639.33
268	8/1/2012	9/1/2012	5/31/2014	I	21	282.41			
269	8/1/2012	9/1/2012	12/31/2039	A	11	115.81	2	60.08	55.73
270	8/1/2012	9/1/2012	12/31/2039	A	8	593.78	3	95.23	498.55
271	8/1/2012	9/1/2012	12/31/2039	A	12	258.12	13	203.16	54.96
272	8/1/2012	9/1/2012	12/31/2039	A	9	2378.7199	8	3512.5	-1133.7801
273	8/1/2012	9/1/2012	12/31/2039	A	10	11.65	10	12.55	-0.9
274	8/1/2012	9/1/2012	12/31/2039	A	8	133.29	6	157.55	-24.26
275	8/1/2012	9/1/2012	12/31/2039	A	8	316.25			316.25
276	8/1/2012	9/1/2012	12/31/2039	A	5	169.15			169.15
277	8/1/2012	9/1/2012	12/31/2039	A	7	212.92	5	105.17	107.75
278	8/1/2012	9/1/2012	9/6/2013	I	5	257.27			
279	8/1/2012	9/1/2012	12/31/2039	A	10	213.98	5	2352	-2138.02
280	8/1/2012	9/1/2012	10/31/2012	I	13	949.68			
281	8/1/2012	9/1/2012	12/31/2039	A	15	3411.21	9	3176.16	235.05
282	8/1/2012	9/1/2012	12/31/2039	A	2	15.32	11	18	-2.68
283	8/1/2012	9/1/2012	12/31/2039	A	1	76.04	5	103.29	-27.25
284	8/1/2012	9/1/2012	2/14/2013	I	16	1011.58			
285	8/1/2012	9/1/2012	12/31/2039	A	19	363.94	23	2204.45	-1840.51
286	8/1/2012	9/1/2012	12/31/2039	A	4	374.94	9	199.27	175.67
287	8/1/2012	9/1/2012	10/31/2012	I	20	808.51			
288	8/1/2012	9/1/2012	12/31/2039	A	2	74.19			74.19
289	8/1/2012	9/1/2012	12/31/2039	A	18	1868.32	27	4209.75	-2341.43
290	8/1/2012	9/1/2012	12/20/2014	I	19	1525.65			
291	8/1/2012	9/1/2012	12/31/2039	A	9	182.36	8	1277.22	-1094.86
292	8/1/2012	9/1/2012	12/31/2039	A	9	971.73	5	218.78	752.95
293	8/1/2012	9/1/2012	2/12/2014	I	10	1259.71			
294	9/1/2012	10/1/2012	12/31/2039	A	6	13.54	3	3.6	9.94
295	9/1/2012	10/1/2012	12/31/2039	A	4	106.95	3	3.6	103.35
296	9/1/2012	10/1/2012	12/31/2039	A	3	8.7899	9	15.6	-6.8101
297	9/1/2012	10/1/2012	1/8/2013	I	16	739.64			
298	9/1/2012	10/1/2012	12/31/2039	A	6	290.9	2	73.41	217.49
299	9/1/2012	10/1/2012	7/31/2015	I	20	282.76	5	61.52	
300	9/1/2012	10/1/2012	12/31/2039	A	10	1231.3699	8	645.24	586.1299
301	9/1/2012	10/1/2012	12/31/2039	A	4	102.66	14	1233.83	-1131.17
302	9/1/2012	10/1/2012	11/21/2012	I	7	342.45			
303	9/1/2012	10/1/2012	12/31/2039	A	5	132.62	5	227.51	-94.89
304	9/1/2012	10/1/2012	12/31/2039	A	4	418.76	10	499.35	-80.59
305	9/1/2012	10/1/2012	12/31/2039	A	6	144.6699			144.6699

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
306	9/1/2012	10/1/2012	12/31/2039	A	2	185.82			185.82
307	9/1/2012	10/1/2012	7/31/2015	I	9	23.18			
308	9/1/2012	10/1/2012	12/31/2039	A	9	2490.43	4	95.27	2395.16
309	9/1/2012	10/1/2012	12/31/2039	A	7	166.61			166.61
310	9/1/2012	10/1/2012	12/31/2039	A	12	192.35	14	450.02	-257.67
311	9/1/2012	10/1/2012	12/31/2039	A	8	240.28	2	123.57	116.71
312	9/1/2012	10/1/2012	12/31/2039	A	6	76.5	4	57.52	18.98
313	9/1/2012	10/1/2012	7/28/2014	I	15	442.5			
314	9/1/2012	10/1/2012	12/31/2039	A	13	1443.88	5	306.47	1137.41
315	9/1/2012	10/1/2012	6/30/2015	I	0	0			
316	9/1/2012	10/1/2012	12/31/2039	A	6	200.56	2	32.89	167.67
317	9/1/2012	10/1/2012	12/31/2039	A	27	850.86	13	1327.9	-477.04
318	9/1/2012	10/1/2012	12/31/2039	A	12	275.02	9	1274.09	-999.07
319	9/1/2012	10/1/2012	2/3/2013	I	16	221.14			
320	9/1/2012	10/1/2012	2/28/2015	I	1	10.1199			
321	9/1/2012	10/1/2012	12/31/2039	A	5	62.39	4	47.71	14.68
322	9/1/2012	10/1/2012	12/31/2039	A	5	65.06	29	502.69	-437.63
323	9/1/2012	10/1/2012	12/31/2039	A	5	620.89	9	1345.72	-724.83
324	9/1/2012	10/1/2012	12/31/2039	A	11	1204.65	9	528.37	676.28
325	9/1/2012	10/1/2012	8/31/2013	I	8	129.37			
326	9/1/2012	10/1/2012	12/31/2039	A	7	22.54			22.54
327	9/1/2012	10/1/2012	12/31/2039	A	15	2216.91	5	1691.48	525.43
328	9/1/2012	10/1/2012	5/31/2013	I	14	246.25			
329	9/1/2012	10/1/2012	12/31/2039	A	6	47.82			47.82
330	9/1/2012	10/1/2012	12/31/2039	A	9	11.01	4	7.2	3.81
331	9/1/2012	10/1/2012	12/31/2039	A	15	2552.55	8	2832.2399	-279.6899
332	9/1/2012	10/1/2012	12/31/2039	A	9	1429.82	11	454.09	975.73
333	10/1/2012	11/1/2012	12/31/2039	A	9	1871.12	8	1770.28	100.84
334	10/1/2012	11/1/2012	12/31/2039	A	5	20.78	3	3.6	17.18
335	10/1/2012	11/1/2012	12/31/2039	A	14	95.75	7	20.91	74.84
336	10/1/2012	11/1/2012	7/31/2014	I	13	524.33			
337	10/1/2012	11/1/2012	12/31/2039	A	3	39	3	36.32	2.68
338	10/1/2012	11/1/2012	12/31/2039	A	12	20.04	6	9.6	10.44
339	10/1/2012	11/1/2012	12/31/2039	A	25	1195.09	28	844.89	350.2
340	10/1/2012	11/1/2012	7/31/2013	I	9	811.44			
341	10/1/2012	11/1/2012	12/31/2039	A	13	35.38	21	36.01	-0.63
342	10/1/2012	11/1/2012	12/31/2039	A	9	382.89	12	447.75	-64.86
343	10/1/2012	11/1/2012	10/31/2012	I	1	1.1			
344	10/1/2012	11/1/2012	7/31/2015	I	18	1963.12	5	471.59	
345	10/1/2012	11/1/2012	12/31/2039	A	6	130.56	9	634.24	-503.68

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
346	10/1/2012	11/1/2012	12/31/2039	A	3	47.9099			47.9099
347	10/1/2012	11/1/2012	12/31/2039	A	13	213.9	7	64.39	149.51
348	10/1/2012	11/1/2012	12/31/2039	A	3	23.3			23.3
349	10/1/2012	11/1/2012	12/31/2039	A	11	195.35	4	92.9599	102.3901
350	10/1/2012	11/1/2012	12/31/2039	A	7	178	7	134.38	43.62
351	10/1/2012	11/1/2012	2/18/2013	I	27	297.02			
352	10/1/2012	11/1/2012	12/31/2039	A	15	1771.05	6	946.28	824.77
353	10/1/2012	11/1/2012	12/31/2039	A	7	1828.99	4	30.99	1798
354	10/1/2012	11/1/2012	12/31/2039	A	5	96.5			96.5
355	10/1/2012	11/1/2012	12/31/2039	A	13	1969.52	9	567.13	1402.39
356	10/1/2012	11/1/2012	12/31/2039	A	10	165.27	9	387.0299	-221.7599
357	10/1/2012	11/1/2012	12/31/2039	A	13	167.08	9	250.21	-83.13
358	10/1/2012	11/1/2012	4/30/2014	I	12	392.55			
359	11/1/2012	12/1/2012	7/31/2015	I	10	307.86	6	757.47	
360	11/1/2012	12/1/2012	12/31/2039	A	8	409.47	3	30.17	379.3
361	11/1/2012	12/1/2012	12/31/2039	A	18	337.45	2	35.97	301.48
362	11/1/2012	12/1/2012	12/31/2014	I	13	1085.53			
363	11/1/2012	12/1/2012	8/22/2014	I	2	82.66			
364	11/1/2012	12/1/2012	5/31/2013	I	11	296.39			
365	11/1/2012	12/1/2012	12/31/2039	A	16	209.43	12	535.39	-325.96
366	11/1/2012	12/1/2012	4/29/2015	I	25	518.9			
367	11/1/2012	12/1/2012	11/15/2014	I	15	2019.39			
368	11/1/2012	12/1/2012	11/30/2014	I	7	488.79			
369	11/1/2012	12/1/2012	12/31/2039	A	11	138.28	2	443.27	-304.99
370	11/1/2012	12/1/2012	12/31/2039	A	15	3133.53	3	149.38	2984.15
371	11/1/2012	12/1/2012	12/13/2014	I	3	74.73			
372	11/1/2012	12/1/2012	12/31/2039	A	5	72.79	4	9.6	63.19
373	11/1/2012	12/1/2012	12/31/2039	A	2	78.75	4	4.8	73.95
374	11/1/2012	12/1/2012	8/31/2013	I	11	616.5599			
375	11/1/2012	12/1/2012	12/31/2039	A	92	1333.09			1333.09
376	11/1/2012	12/1/2012	6/30/2013	I	8	409.8399			
377	11/1/2012	12/1/2012	6/30/2013	I	15	307.12			
378	11/1/2012	12/1/2012	12/31/2039	A	15	795.42			795.42
379	11/1/2012	12/1/2012	12/31/2039	A	17	364.11	17	785.17	-421.06
380	11/1/2012	12/1/2012	12/31/2039	A	12	597.51	10	442.88	154.63
381	11/1/2012	12/1/2012	1/31/2015	I	23	2723.36			
382	11/1/2012	12/1/2012	12/31/2039	A	13	435.31	12	685.6799	-250.3699
383	11/1/2012	12/1/2012	12/31/2039	A	15	1326.96	2	55.22	1271.74
384	12/1/2012	1/1/2013	12/31/2039	A	12	351.74	31	706.54	-354.8
385	12/1/2012	1/1/2013	3/26/2014	I	4	11.92			

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
386	12/1/2012	1/1/2013	12/31/2039	A	11	163.75	9	998.38	-834.63
387	12/1/2012	1/1/2013	12/31/2039	A	13	1909.13	8	782.91	1126.22
388	12/1/2012	1/1/2013	1/31/2015	I	6	24.13			
389	12/1/2012	1/1/2013	12/31/2039	A	13	238.21	15	474.12	-235.91
390	12/1/2012	1/1/2013	5/31/2014	I	11	1521.3699			
391	12/1/2012	1/1/2013	12/31/2039	A	13	560.05			560.05
392	12/1/2012	1/1/2013	12/31/2039	A	9	214.55	8	145.36	69.19
393	12/1/2012	1/1/2013	10/6/2013	I	17	709.17			
394	12/1/2012	1/1/2013	3/14/2015	I	8	1843.99			
395	12/1/2012	1/1/2013	12/31/2039	A	8	284.5	6	465.52	-181.02
396	12/1/2012	1/1/2013	2/20/2015	I	7	112.61			
397	12/1/2012	1/1/2013	12/31/2039	A	8	160.79	22	2397.76	-2236.97
398	12/1/2012	1/1/2013	12/31/2039	A	10	404.16	6	148.32	255.84
399	12/1/2012	1/1/2013	12/31/2039	A	8	657.79	9	885.96	-228.17
400	12/1/2012	1/1/2013	6/30/2015	I	6	45.99			
401	12/1/2012	1/1/2013	12/31/2039	A	14	1013.51	4	72	941.51
402	12/1/2012	1/1/2013	12/31/2039	A	13	530.26	3	131.77	398.49
403	12/1/2012	1/1/2013	12/31/2039	A	18	1246.42	15	5700.76	-4454.34
404	12/1/2012	1/1/2013	8/31/2015	A	10	36.24	4	9.85	26.39
405	12/1/2012	1/1/2013	12/31/2039	A	8	542.77	6	715.98	-173.21
406	12/1/2012	1/1/2013	12/31/2039	A	17	729.1	10	498.52	230.58
407	12/1/2012	1/1/2013	12/31/2039	A	3	138.4199	3	61.01	77.4099
408	12/1/2012	1/1/2013	12/31/2039	A					0
409	12/1/2012	1/1/2013	3/27/2014	I	15	5960.52			
410	12/1/2012	1/1/2013	12/31/2039	A	17	211.66	15	115.04	96.62
411	1/1/2013	2/1/2013	5/31/2015	I	2	0.28			
412	1/1/2013	2/1/2013	12/31/2039	A	13	592.9299	4	45.6	547.3299
413	1/1/2013	2/1/2013	12/31/2039	A	19	528.51	9	930.41	-401.9
414	1/1/2013	2/1/2013	12/31/2039	A	16	418.01	16	1503.55	-1085.54
415	1/1/2013	2/1/2013	8/31/2015	A	8	469.06	1	5.7699	463.2901
416	1/1/2013	2/1/2013	8/31/2015	A	11	582.73	4	75.91	506.82
417	1/1/2013	2/1/2013	12/31/2039	A	20	896.08	8	400.41	495.67
418	1/1/2013	2/1/2013	12/31/2039	A	7	190.83	8	544.13	-353.3
419	1/1/2013	2/1/2013	12/31/2039	A	8	507.41	6	102.63	404.78
420	1/1/2013	2/1/2013	12/31/2039	A	17	964.53	23	1861.8	-897.27
421	1/1/2013	2/1/2013	12/31/2039	A	10	150.18	7	61.91	88.27
422	1/1/2013	2/1/2013	12/31/2039	A	13	1404.38	7	1317.39	86.99
423	1/1/2013	2/1/2013	3/24/2013	I	14	5070.3			
424	1/1/2013	2/1/2013	8/31/2013	I	12	299.49			
425	1/1/2013	2/1/2013	7/31/2015	I	5	278.15	1	327.81	

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
426	1/1/2013	2/1/2013	12/31/2039	A	12	695.9	11	3384.3	-2688.4
427	1/1/2013	2/1/2013	9/30/2013	I	20	131.58			
428	1/1/2013	2/1/2013	12/31/2039	A	13	904.53	3	381.83	522.7
429	1/1/2013	2/1/2013	11/8/2014	I	11	12.1			
430	1/1/2013	2/1/2013	12/31/2039	A	2	2.2			2.2
431	1/1/2013	2/1/2013	5/31/2015	I	8	493.85			
432	1/1/2013	2/1/2013	12/31/2039	A	19	1500.17	4	57.21	1442.96
433	1/1/2013	2/1/2013	5/30/2015	I	19	864.94			
434	1/1/2013	2/1/2013	12/31/2039	A	10	748.01	6	7.2	740.81
435	1/1/2013	2/1/2013	12/31/2039	A	24	496.34	25	1537.3	-1040.96
436	1/1/2013	2/1/2013	12/31/2039	A	20	565.71	6	434.21	131.5
437	2/1/2013	3/1/2013	12/31/2039	A	7	472.14	1	10.93	461.21
438	2/1/2013	3/1/2013	12/31/2039	A	5	5746.39			5746.39
439	2/1/2013	3/1/2013	12/31/2039	A	5	188.93	15	362.3	-173.37
440	2/1/2013	3/1/2013	12/31/2039	A	6	1572.95	53	51363.3	-49790.35
441	2/1/2013	3/1/2013	12/31/2039	A	8	146.95	7	447.16	-300.21
442	2/1/2013	3/1/2013	12/31/2039	A	11	183.27	3	35.1	148.17
443	2/1/2013	3/1/2013	6/30/2014	I	6	174.9199			
444	2/1/2013	3/1/2013	12/31/2039	A	6	161.1699	2	574.4	-413.2301
445	2/1/2013	3/1/2013	12/31/2039	A	6	74.28	11	811.51	-737.23
446	2/1/2013	3/1/2013	2/16/2013	I	3	313.08			
447	2/1/2013	3/1/2013	12/31/2039	A	12	1555.31	23	1131	424.31
448	2/1/2013	3/1/2013	12/31/2039	A	12	554.63	23	1617.22	-1062.59
449	2/1/2013	3/1/2013	10/29/2013	I	6	8.8			
450	2/1/2013	3/1/2013	12/31/2039	A	18	640.54	15	1039.79	-399.25
451	2/1/2013	3/1/2013	10/31/2014	I					
452	2/1/2013	3/1/2013	12/31/2039	A	14	1235	16	1314.85	-79.85
453	2/1/2013	3/1/2013	6/30/2013	I	8	152.35			
454	2/1/2013	3/1/2013	11/30/2013	I	10	157.74			
455	2/1/2013	3/1/2013	12/31/2039	A	16	403.36	14	462.92	-59.56
456	2/1/2013	3/1/2013	6/20/2014	I	9	341.74			
457	2/1/2013	3/1/2013	12/31/2039	A	10	193.99	8	62.7	131.29
458	2/1/2013	3/1/2013	12/31/2039	A	19	107.53	2	2.4	105.13
459	2/1/2013	3/1/2013	12/31/2039	A	7	192.96	18	920.84	-727.88
460	2/1/2013	3/1/2013	5/31/2013	I	8	259.13			
461	2/1/2013	3/1/2013	12/31/2039	A	4	650.39			650.39
462	2/1/2013	3/1/2013	12/31/2039	A	20	273.56	6	49.81	223.75
463	2/1/2013	3/1/2013	12/31/2039	A	36	2058.46	5	57.76	2000.7
464	2/1/2013	3/1/2013	12/31/2039	A	7	627.17			627.17
465	2/1/2013	3/1/2013	12/31/2039	A	38	132.44	8	59.2	73.24

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
466	2/1/2013	3/1/2013	12/31/2039	A	10	508.42	18	1352.46	-844.04
467	2/1/2013	3/1/2013	12/31/2039	A	12	1476.23	8	17472.11	-15995.88
468	2/22/2013	3/22/2013	12/31/2039	A	1	26.35			26.35
469	3/1/2013	4/1/2013	12/31/2039	A	7	126.53			126.53
470	3/1/2013	4/1/2013	12/31/2039	A	6	194.24	8	392.21	-197.97
471	3/1/2013	4/1/2013	12/31/2039	A	9	643.36	7	1222.96	-579.6
472	3/1/2013	4/1/2013	12/31/2039	A	8	68.2			68.2
473	3/1/2013	4/1/2013	12/31/2039	A	7	131.34	3	115.06	16.28
474	3/1/2013	4/1/2013	12/31/2039	A	9	442.39	8	219.14	223.25
475	3/1/2013	4/1/2013	12/31/2039	A	10	1390.79	8	1111.8599	278.9301
476	3/1/2013	4/1/2013	12/31/2039	A	6	119.13			119.13
477	3/1/2013	4/1/2013	7/31/2015	I	11	238.46			
478	3/1/2013	4/1/2013	12/31/2039	A	8	164.6399	9	421.77	-257.1301
479	3/1/2013	4/1/2013	12/31/2039	A					0
480	3/1/2013	4/1/2013	12/31/2039	A	24	904.86	34	1391.53	-486.67
481	3/1/2013	4/1/2013	12/31/2039	A	5	97.9599	9	2116.92	-2018.9601
482	3/1/2013	4/1/2013	8/31/2013	I	7	82.27			
483	3/1/2013	4/1/2013	12/31/2039	A	3	59.14	1	55.78	3.36
484	3/1/2013	4/1/2013	12/31/2039	A	10	17.6	1	65.14	-47.54
485	3/1/2013	4/1/2013	12/31/2039	A	36	3484.35	30	2135.69	1348.66
486	3/1/2013	4/1/2013	8/31/2013	I	1	7.23			
487	3/1/2013	4/1/2013	12/31/2039	A	5	50.07			50.07
488	3/1/2013	4/1/2013	12/31/2039	A	16	477.5	6	88.04	389.46
489	4/1/2013	5/1/2013	12/31/2039	A	18	1080.13	7	279.32	800.81
490	4/1/2013	5/1/2013	12/31/2039	A	8	154.55	4	379.23	-224.68
491	4/1/2013	5/1/2013	1/31/2015	I	14	753.21			
492	4/1/2013	5/1/2013	7/21/2014	I	5	273.69			
493	4/1/2013	5/1/2013	6/30/2015	I	20	4016.09			
494	4/1/2013	5/1/2013	12/31/2039	A					0
495	4/1/2013	5/1/2013	12/31/2039	A	10	365.64	5	102.19	263.45
496	4/1/2013	5/1/2013	12/31/2039	A	9	489.16	6	275.27	213.89
497	4/1/2013	5/1/2013	12/31/2039	A	4	183.25	10	139.74	43.51
498	4/1/2013	5/1/2013	12/31/2039	A	16	1737.23	19	1799.82	-62.59
499	4/1/2013	5/1/2013	12/31/2039	A	5	106.54	7	330.41	-223.87
500	4/1/2013	5/1/2013	12/31/2039	A	15	993.33	9	394.87	598.46
501	4/1/2013	5/1/2013	12/31/2039	A	6	762.22	1	8.26	753.96
502	4/1/2013	5/1/2013	12/31/2039	A	29	870.63	5	198.75	671.88
503	4/1/2013	5/1/2013	7/31/2015	I	7	662.54			
504	4/1/2013	5/1/2013	12/31/2039	A	14	2413.32	7	115.21	2298.11
505	5/1/2013	6/1/2013	11/30/2013	I	9	10691.09			

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
506	5/1/2013	6/1/2013	4/30/2014	I	20	367.51			
507	5/1/2013	6/1/2013	12/31/2039	A	4	80.87	9	378.86	-297.99
508	5/1/2013	6/1/2013	12/31/2039	A	5	89.7	6	365	-275.3
509	5/1/2013	6/1/2013	12/31/2039	A	11	40.93	7	10.8	30.13
510	5/1/2013	6/1/2013	12/31/2039	A	2	4.4	8	9.65	-5.25
511	5/1/2013	6/1/2013	12/31/2039	A	7	330.16	2	132	198.16
512	5/1/2013	6/1/2013	12/31/2039	A	9	391.26	6	260.92	130.34
513	5/1/2013	6/1/2013	12/31/2039	A	15	1773.57	4	27.87	1745.7
514	5/1/2013	6/1/2013	12/31/2039	A	6	6.65	12	16.8	-10.15
515	10/1/2013	11/1/2013	12/31/2039	A	28	401.51			401.51
516	10/1/2013	11/1/2013	12/31/2039	A	4	248.33	4	84.74	163.59
517	10/1/2013	11/1/2013	12/31/2039	A	11	232.54	13	209.72	22.82
518	10/1/2013	11/1/2013	12/31/2039	A	16	952.45	31	1747.25	-794.8
519	10/1/2013	11/1/2013	12/31/2039	A	3	50.4799	2	26.54	23.9399
520	10/1/2013	11/1/2013	10/31/2014	I	7	343.83			
521	10/1/2013	11/1/2013	2/13/2015	I	19	1033.6			
522	10/1/2013	11/1/2013	12/31/2039	A	25	1634.59	15	1955.36	-320.77
523	10/1/2013	11/1/2013	12/31/2039	A	19	732.58	15	730.69	1.89
524	10/1/2013	11/1/2013	12/31/2039	A	8	18.9			18.9
525	10/1/2013	11/1/2013	12/31/2039	A					0
526	10/1/2013	11/1/2013	12/31/2039	A	20	575.14	32	1019.4	-444.26
527	10/1/2013	11/1/2013	12/31/2039	A	12	682.58	29	6176.72	-5494.14
528	10/1/2013	11/1/2013	10/31/2014	I	17	976.76			
529	10/1/2013	11/1/2013	8/31/2014	I	10	55.36			
530	10/1/2013	11/1/2013	8/31/2015	A	9	168.91	3	3.6	165.31
531	10/1/2013	11/1/2013	12/31/2039	A	18	487.29	13	396.81	90.48
532	10/1/2013	11/1/2013	12/31/2039	A	6	80.54			80.54
533	10/1/2013	11/1/2013	12/31/2039	A	5	790.1	6	667.89	122.21
534	10/1/2013	11/1/2013	1/2/2015	I	6	364.5			
535	10/1/2013	11/1/2013	12/31/2039	A	6	5.75	16	25.8	-20.05
536	10/1/2013	11/1/2013	12/31/2039	A	10	368.91	4	118.11	250.8
537	10/1/2013	11/1/2013	12/31/2039	A	6	214.09	17	502.07	-287.98
538	10/1/2013	11/1/2013	11/21/2013	I	12	1037.7			
539	10/1/2013	11/1/2013	12/31/2039	A	23	1078.52	3	37.9099	1040.6101
540	10/1/2013	11/1/2013	12/31/2039	A			13	731.59	-731.59
541	10/1/2013	11/1/2013	4/30/2014	I	16	159.65			
542	10/1/2013	11/1/2013	12/31/2039	A	22	386.3	6	1439.54	-1053.24
543	10/1/2013	11/1/2013	12/31/2039	A	16	238.41	13	674.02	-435.61
544	10/1/2013	11/1/2013	12/31/2039	A	8	183.49	11	1193.97	-1010.48
545	10/1/2013	11/1/2013	12/31/2039	A	13	845.44	9	5966.95	-5121.51

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
546	11/1/2013	12/1/2013	12/31/2039	A	6	73.34			73.34
547	11/1/2013	12/1/2013	12/31/2039	A	19	1004.68	14	550.99	453.69
548	11/1/2013	12/1/2013	12/31/2039	A	27	1048.3699	12	1227.02	-178.6501
549	11/1/2013	12/1/2013	12/31/2039	A	8	826.24	5	363.18	463.06
550	11/1/2013	12/1/2013	12/31/2039	A	5	107.12	4	86.38	20.74
551	11/1/2013	12/1/2013	12/31/2039	A	1	76.55			76.55
552	11/1/2013	12/1/2013	12/31/2039	A	7	12.75	2	16.15	-3.4
553	11/1/2013	12/1/2013	12/31/2039	A	15	919.38	16	762.48	156.9
554	11/1/2013	12/1/2013	12/31/2039	A	7	542.4	11	488.46	53.94
555	11/1/2013	12/1/2013	12/31/2039	A	9	169.01	3	70.5	98.51
556	11/1/2013	12/1/2013	12/31/2039	A	17	14839.48	21	2491.2399	12348.2401
557	11/1/2013	12/1/2013	12/31/2039	A	11	3846.73	5	1434.65	2412.08
558	11/1/2013	12/1/2013	12/31/2039	A	14	4026.27	8	488.37	3537.9
559	11/1/2013	12/1/2013	12/31/2039	A	10	67.06	4	142.18	-75.12
560	12/1/2013	1/1/2014	12/31/2039	A	11	676.61	4	4.8	671.81
561	12/1/2013	1/1/2014	12/31/2039	A	23	1025.85	15	1223.54	-197.69
562	12/1/2013	1/1/2014	12/31/2039	A	19	1929.24	2	2115.98	-186.74
563	12/1/2013	1/1/2014	12/31/2039	A	10	25.4			25.4
564	12/1/2013	1/1/2014	12/31/2039	A	11	2208.69	11	2254.38	-45.69
565	12/1/2013	1/1/2014	12/31/2039	A	11	263.66	8	702.78	-439.12
566	12/1/2013	1/1/2014	12/31/2039	A	4	764.16	1	18.25	745.91
567	12/1/2013	1/1/2014	12/31/2039	A	3	32.36	3	75.37	-43.01
568	12/1/2013	1/1/2014	9/23/2014	I	4	68.4			
569	12/1/2013	1/1/2014	12/31/2039	A	7	116.38	1	15.79	100.59
570	12/1/2013	1/1/2014	12/31/2039	A	12	154.35	17	585.9299	-431.5799
571	12/1/2013	1/1/2014	3/18/2015	I	15	715.79			
572	12/1/2013	1/1/2014	12/31/2039	A	9	413.3	12	1581.1099	-1167.8099
573	12/1/2013	1/1/2014	12/31/2039	A	11	162.11	7	433.74	-271.63
574	1/1/2014	2/1/2014	12/31/2039	A	6	7.2	3	3.6	3.6
575	1/1/2014	2/1/2014	12/31/2039	A	21	411.5299	10	1649.13	-1237.6001
576	1/1/2014	2/1/2014	12/31/2039	A	12	979.89	3	25.69	954.2
577	1/1/2014	2/1/2014	12/31/2039	A	9	1454.31	2	29.21	1425.1
578	1/1/2014	2/1/2014	6/30/2014	I	7	303.46			
579	1/1/2014	2/1/2014	12/31/2039	A	9	1081.14	4	112.89	968.25
580	1/1/2014	2/1/2014	12/31/2039	A	17	2470.03			2470.03
581	1/1/2014	2/1/2014	12/31/2039	A	5	1003.4	9	633.05	370.35
582	1/1/2014	2/1/2014	12/31/2039	A	11	1658.83	11	1375.91	282.92
583	1/1/2014	2/1/2014	12/31/2039	A	11	3101.9899	14	2232.4899	869.5
584	1/1/2014	2/1/2014	12/31/2039	A	7	262.7799	10	498.26	-235.4801
585	1/1/2014	2/1/2014	12/31/2039	A	18	1036.43			1036.43

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
586	1/1/2014	2/1/2014	12/31/2039	A	11	2241.23	5	699.23	1542
587	1/1/2014	2/1/2014	12/31/2039	A	10	1682.58	11	1608.3	74.28
588	1/1/2014	2/1/2014	12/31/2039	A	7	257.47	6	212.24	45.23
589	1/1/2014	2/1/2014	4/20/2014	I	63	676			
590	1/1/2014	2/1/2014	12/31/2039	A	7	152.46	7	457.42	-304.96
591	1/1/2014	2/1/2014	12/31/2039	A	19	927.7	10	138.82	788.88
592	1/1/2014	2/1/2014	7/31/2014	I	10	391.73			
593	1/1/2014	2/1/2014	12/31/2039	A	12	271.94			271.94
594	1/1/2014	2/1/2014	12/31/2039	A	10	1381.21			1381.21
595	1/1/2014	2/1/2014	12/31/2039	A	24	1659.3	16	787.85	871.45
596	1/1/2014	2/1/2014	12/31/2039	A	49	48180.76	71	77607.32	-29426.56
597	1/1/2014	2/1/2014	3/31/2014	I	12	61.16			
598	1/1/2014	2/1/2014	12/31/2039	A	18	2028.58	5	103.45	1925.13
599	2/1/2014	3/1/2014	12/31/2039	A	8	363.51	9	399.24	-35.73
600	2/1/2014	3/1/2014	12/31/2039	A	11	420.55	10	1499.06	-1078.51
601	2/1/2014	3/1/2014	12/31/2039	A	14	680.39			680.39
602	2/1/2014	3/1/2014	12/31/2039	A	9	395.12	3	46.49	348.63
603	2/1/2014	3/1/2014	12/31/2039	A	13	1457.3			1457.3
604	2/1/2014	3/1/2014	12/31/2039	A	12	536.58	10	947.43	-410.85
605	2/1/2014	3/1/2014	1/31/2014	I					
606	2/1/2014	3/1/2014	12/31/2039	A	8	878.01	2	47.82	830.19
607	2/1/2014	3/1/2014	5/31/2015	I					
608	2/1/2014	3/1/2014	7/31/2015	I	7	74.84	5	37.6599	
609	2/1/2014	3/1/2014	12/31/2039	A	10	337.13	8	389.85	-52.72
610	2/1/2014	3/1/2014	12/31/2039	A	11	902.82	7	514.47	388.35
611	2/1/2014	3/1/2014	12/31/2039	A	47	692.52			692.52
612	2/1/2014	3/1/2014	12/31/2039	A	6	187.62	9	229.29	-41.67
613	2/1/2014	3/1/2014	12/31/2039	A	7	1035.13	8	108.44	926.69
614	2/1/2014	3/1/2014	11/30/2014	I	16	1012.65			
615	2/1/2014	3/1/2014	12/31/2039	A	7	1001.14	3	41.6	959.54
616	2/1/2014	3/1/2014	12/31/2039	A	8	438.84			438.84
617	2/1/2014	3/1/2014	12/31/2039	A	4	102.23			102.23
618	2/1/2014	3/1/2014	12/31/2039	A	4	62.17	19	861.46	-799.29
619	2/1/2014	3/1/2014	12/31/2039	A	17	852.38	9	473.35	379.03
620	2/1/2014	3/1/2014	12/31/2039	A	26	1355.27	7	118.31	1236.96
621	2/1/2014	3/1/2014	1/31/2015	I	11	862.41			
622	2/1/2014	3/1/2014	12/31/2039	A	29	164.91	6	83.23	81.68
623	2/1/2014	3/1/2014	7/31/2015	I	30	285.06			
624	2/1/2014	3/1/2014	12/31/2039	A	11	862.67	11	651.29	211.38
625	2/1/2014	3/1/2014	12/31/2039	A	20	1532.22	19	669.4	862.82

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
626	2/1/2014	3/1/2014	12/31/2039	A	12	924.18	12	764.71	159.47
627	2/1/2014	3/1/2014	12/31/2039	A	13	288.75	5	74.99	213.76
628	2/1/2014	3/1/2014	12/31/2039	A	13	1016.7	7	133.94	882.76
629	2/1/2014	3/1/2014	12/31/2039	A	25	1174.68	7	108.34	1066.34
630	2/1/2014	3/1/2014	12/31/2039	A	19	682.28	16	1333.99	-651.71
631	2/1/2014	3/1/2014	12/31/2039	A	19	1564.21	4	294.24	1269.97
632	2/1/2014	3/1/2014	12/31/2039	A	4	2556.71			2556.71
633	2/1/2014	3/1/2014	12/31/2039	A	4	138.25			138.25
634	3/1/2014	4/1/2014	12/31/2039	A	7	1315.47	6	7.2	1308.27
635	3/1/2014	4/1/2014	12/31/2039	A	15	66.17			66.17
636	3/1/2014	4/1/2014	12/31/2039	A	5	67.49			67.49
637	3/1/2014	4/1/2014	12/31/2039	A	17	1386.89	10	1546.76	-159.87
638	3/1/2014	4/1/2014	12/31/2039	A	21	86.31	18	160.91	-74.6
639	3/1/2014	4/1/2014	8/31/2014	I	16	1543.34			
640	3/1/2014	4/1/2014	12/31/2039	A	27	1415.54	19	4789.55	-3374.01
641	3/1/2014	4/1/2014	12/31/2039	A	16	1499.24	8	779.15	720.09
642	3/1/2014	4/1/2014	12/31/2039	A	16	4729.65	3	345.5299	4384.1201
643	3/1/2014	4/1/2014	12/31/2039	A	7	214.15	8	440.79	-226.64
644	3/1/2014	4/1/2014	12/31/2039	A	27	2385.08			2385.08
645	3/1/2014	4/1/2014	12/31/2039	A	18	2317.36			2317.36
646	3/1/2014	4/1/2014	1/6/2015	I	9	309.48			
647	3/1/2014	4/1/2014	12/31/2039	A	23	727.4	11	646.89	80.51
648	3/1/2014	4/1/2014	9/30/2014	I	2	4.8			
649	3/1/2014	4/1/2014	12/31/2039	A	7	96.35			96.35
650	3/1/2014	4/1/2014	12/31/2039	A	10	117.4	3	32.81	84.59
651	3/1/2014	4/1/2014	12/31/2039	A			3	58.25	-58.25
652	3/1/2014	4/1/2014	12/31/2039	A	12	19.2	15	20.4	-1.2
653	3/1/2014	4/1/2014	12/31/2039	A	6	764.55	3	1120.7	-356.15
654	3/1/2014	4/1/2014	12/31/2039	A	12	1485.21	25	3074.52	-1589.31
655	3/1/2014	4/1/2014	12/31/2039	A	14	491.34	3	213.16	278.18
656	4/1/2014	5/1/2014	12/31/2039	A	7	55.42	5	106.07	-50.65
657	4/1/2014	5/1/2014	12/31/2039	A	12	142.3899	2	161.32	-18.9301
658	4/1/2014	5/1/2014	12/31/2039	A	13	337.43	7	211.83	125.6
659	4/1/2014	5/1/2014	8/31/2014	I	6	131.86			
660	4/1/2014	5/1/2014	12/31/2039	A	15	26.13	13	25.5799	0.5501
661	4/1/2014	5/1/2014	12/31/2039	A	10	175.59	5	722.11	-546.52
662	4/1/2014	5/1/2014	12/31/2039	A	14	697.99	26	556.3	141.69
663	4/1/2014	5/1/2014	12/31/2039	A	10	546.58	5	363.48	183.1
664	4/1/2014	5/1/2014	12/31/2039	A	9	465.33	17	551.79	-86.46
665	4/1/2014	5/1/2014	12/31/2039	A	4	1240.18	5	70.58	1169.6

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
666	4/1/2014	5/1/2014	12/31/2039	A	25	2165.9899			2165.9899
667	4/1/2014	5/1/2014	12/31/2039	A	8	106.4	1	11.85	94.55
668	4/1/2014	5/1/2014	12/31/2039	A	32	210.19	29	465.5	-255.31
669	4/1/2014	5/1/2014	8/31/2015	A	14	119.75			119.75
670	4/1/2014	5/1/2014	12/31/2039	A	24	2910.94	11	1785.33	1125.61
671	4/1/2014	5/1/2014	7/31/2015	I	16	215.94	15	271.88	
672	4/1/2014	5/1/2014	12/31/2039	A	13	1101.25	7	1020.21	81.04
673	4/1/2014	5/1/2014	12/31/2039	A	12	1109.95	13	1364.65	-254.7
674	4/1/2014	5/1/2014	12/31/2039	A					0
675	5/1/2014	6/1/2014	12/31/2039	A	6	96.66			96.66
676	5/1/2014	6/1/2014	12/31/2039	A	6	7.2	9	16.43	-9.23
677	5/1/2014	6/1/2014	12/31/2039	A	8	5299.54	7	6416.91	-1117.37
678	5/1/2014	6/1/2014	12/31/2039	A	10	270.31	14	633.49	-363.18
679	5/1/2014	6/1/2014	12/31/2039	A	11	572.54	33	1980.27	-1407.73
680	5/1/2014	6/1/2014	12/31/2039	A	11	522.34	15	679.96	-157.62
681	5/1/2014	6/1/2014	12/31/2039	A	21	1043.57	25	2556.68	-1513.11
682	5/1/2014	6/1/2014	12/31/2039	A	12	640.9299	14	952.34	-311.4101
683	5/1/2014	6/1/2014	12/31/2039	A	19	39.45	6	377.3	-337.85
684	5/1/2014	6/1/2014	12/31/2039	A	9	2398.2199	4	124.34	2273.8799
685	5/1/2014	6/1/2014	5/31/2014	I	6	2311.31			
686	5/1/2014	6/1/2014	12/31/2039	A	13	857.89			857.89
687	5/1/2014	6/1/2014	12/31/2039	A	8	246.89	5	103.15	143.74
688	6/1/2014	7/1/2014	12/31/2039	A	20	1402.27	13	1081.64	320.63
689	6/1/2014	7/1/2014	12/31/2039	A	3	58.75			58.75
690	6/1/2014	7/1/2014	12/31/2039	A	7	306.99	1	3.46	303.53
691	6/1/2014	7/1/2014	12/31/2039	A	12	1100.8	13	884.45	216.35
692	6/1/2014	7/1/2014	12/31/2039	A	11	385.87	3	131.77	254.1
693	6/1/2014	7/1/2014	12/31/2039	A	6	297.02	13	2840.53	-2543.51
694	6/1/2014	7/1/2014	12/31/2039	A	1	9.57	3	9.09	0.48
695	6/1/2014	7/1/2014	12/31/2039	A	8	64.48	21	3301.9699	-3237.4899
696	6/1/2014	7/1/2014	12/31/2039	A	15	398.71			398.71
697	6/1/2014	7/1/2014	12/31/2039	A	11	733	6	102.05	630.95
698	7/1/2014	8/1/2014	12/31/2039	A	25	19.22			19.22
699	7/1/2014	8/1/2014	12/31/2039	A	12	1944.54	27	2798.63	-854.09
700	7/1/2014	8/1/2014	7/31/2015	I	9	358.99	5	345.45	
701	7/1/2014	8/1/2014	12/31/2039	A	9	94.38	2	311.04	-216.66
702	7/1/2014	8/1/2014	12/31/2039	A	11	236.83	4	358.92	-122.09
703	7/1/2014	8/1/2014	12/31/2039	A	8	289.36	7	394.35	-104.99
704	7/1/2014	8/1/2014	12/31/2039	A	10	781.86	3	823.61	-41.75
705	7/1/2014	8/1/2014	12/31/2039	A	15	1078.1199	12	1664.51	-586.3901

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706	7/1/2014	8/1/2014	12/31/2039	A	26	936.35	15	1272.16	-335.81
707	7/1/2014	8/1/2014	12/31/2039	A	29	168.72			168.72
708	7/1/2014	8/1/2014	12/31/2039	A	24	2118.31	15	1279.94	838.37
709	7/1/2014	8/1/2014	10/10/2014	I	22	931.38			
710	7/1/2014	8/1/2014	6/30/2015	I	15	22.18			
711	7/1/2014	8/1/2014	12/31/2039	A	26	1279.02	16	898.1	380.92
712	7/1/2014	8/1/2014	12/31/2039	A	10	16.8	2	2.4	14.4
713	7/1/2014	8/1/2014	12/31/2039	A	19	20.77	14	426.02	-405.25
714	7/1/2014	8/1/2014	12/31/2039	A	30	134.1399	13	57.92	76.2199
715	8/1/2014	9/1/2014	12/31/2039	A	12	1366.3599	14	2520.62	-1154.2601
716	8/1/2014	9/1/2014	8/31/2015	A	6	110.9	2	110.16	0.74
717	8/1/2014	9/1/2014	12/21/2014	I	10	1477.55			
718	8/1/2014	9/1/2014	12/31/2039	A	10	14.4	13	20.4	-6
719	8/1/2014	9/1/2014	4/30/2015	I	12	561.9299			
720	8/1/2014	9/1/2014	7/31/2015	I	15	392.88	4	484.23	
721	8/1/2014	9/1/2014	12/31/2039	A	19	2090.71	25	2743.7	-652.99
722	8/1/2014	9/1/2014	12/31/2039	A	14	264.2799	4	182.83	81.4499
723	8/1/2014	9/1/2014	12/31/2039	A					0
724	8/1/2014	9/1/2014	12/31/2039	A	20	155.01	16	386.72	-231.71
725	8/1/2014	9/1/2014	3/31/2015	I	4	72.62			
726	8/1/2014	9/1/2014	6/30/2015	I					
727	8/1/2014	9/1/2014	12/31/2039	A	4	132.9	9	14098.33	-13965.43
728	8/1/2014	9/1/2014	12/31/2039	A	12	31491.62	12	3110.39	28381.23
729	9/1/2014	10/1/2014	12/31/2039	A	20	1222.25	16	1180.77	41.48
730	9/1/2014	10/1/2014	12/31/2039	A	15	1382.75	15	1008.35	374.4
731	9/1/2014	10/1/2014	12/31/2039	A	13	96.09	10	88.85	7.24
732	9/1/2014	10/1/2014	3/31/2015	I	17	263.29			
733	9/1/2014	10/1/2014	12/31/2039	A	35	464.13	2	109.42	354.71
734	9/1/2014	10/1/2014	12/31/2039	A	12	1269.02	11	1238.98	30.04
735	9/1/2014	10/1/2014	12/31/2039	A	10	504.7	12	575.82	-71.12
736	9/1/2014	10/1/2014	12/31/2039	A	11	156.49			156.49
737	9/1/2014	10/1/2014	2/28/2015	I	20	716.08			
738	9/1/2014	10/1/2014	12/31/2039	A	19	646.32	2	253.48	392.84
739	9/1/2014	10/1/2014	9/30/2014	I	6	360.52			
740	9/1/2014	10/1/2014	12/31/2039	A	2	47.92			47.92
741	9/1/2014	10/1/2014	12/31/2039	A	18	1220.19	7	475.56	744.63
742	9/1/2014	10/1/2014	12/31/2039	A	10	692.4299	10	1032.56	-340.1301
743	9/1/2014	10/1/2014	12/31/2039	A	14	2734.38	16	4423.25	-1688.87
744	9/1/2014	10/1/2014	12/31/2039	A	2	138.74			138.74
745	9/1/2014	10/1/2014	12/31/2039	A	9	3054.6	13	3389.81	-335.21

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
746	10/1/2014	11/1/2014	12/31/2039	A	10	336.0299	13	690.69	-354.6601
747	10/1/2014	11/1/2014	12/31/2039	A	7	127.74	11	238.93	-111.19
748	10/1/2014	11/1/2014	12/31/2039	A	10	12	4	4.8	7.2
749	10/1/2014	11/1/2014	12/31/2039	A	12	12.16	5	6	6.16
750	10/1/2014	11/1/2014	12/31/2039	A	14	153.91	10	305	-151.09
751	10/1/2014	11/1/2014	12/31/2039	A	44	476.38	5	919.22	-442.84
752	10/1/2014	11/1/2014	12/31/2039	A	19	3693.42	18	4276.7	-583.28
753	10/1/2014	11/1/2014	12/31/2039	A	4	163.7	6	187.59	-23.89
754	10/1/2014	11/1/2014	11/18/2014	I	13	20.4			
755	10/1/2014	11/1/2014	12/31/2039	A	13	1016.15			1016.15
756	10/1/2014	11/1/2014	12/31/2039	A	17	3605.77	11	2254.71	1351.06
757	10/1/2014	11/1/2014	1/31/2015	I	11	604.6			
758	10/1/2014	11/1/2014	2/28/2015	I	3	21.22			
759	10/1/2014	11/1/2014	12/31/2039	A	1	6.19			6.19
760	10/1/2014	11/1/2014	12/31/2039	A	5	59.1	1	23.35	35.75
761	10/1/2014	11/1/2014	12/31/2014	I	57	462.13			
762	10/1/2014	11/1/2014	10/31/2014	I	16	591.51			
763	10/1/2014	11/1/2014	12/31/2039	A	2	160.65	2	50.31	110.34
764	10/1/2014	11/1/2014	12/31/2039	A	20	510.92	15	3484.6	-2973.68
765	11/1/2014	12/1/2014	12/31/2039	A	20	8427.52	13	895.36	7532.16
766	11/1/2014	12/1/2014	12/31/2039	A	21	487.92	12	405.06	82.86
767	11/1/2014	12/1/2014	12/31/2039	A	11	864.79	5	187.46	677.33
768	11/1/2014	12/1/2014	12/31/2039	A	6	59.84	2	45.94	13.9
769	11/1/2014	12/1/2014	7/7/2015	I	7	604.14	1	53.7	
770	11/1/2014	12/1/2014	12/31/2039	A	4	147.78	5	84.81	62.97
771	11/1/2014	12/1/2014	12/31/2039	A	30	228.1	24	203.25	24.85
772	11/1/2014	12/1/2014	12/31/2039	A	16	3473.24	2	70.38	3402.86
773	11/1/2014	12/1/2014	3/31/2015	I	10	62.13			
774	11/1/2014	12/1/2014	12/31/2039	A	20	1328.32	17	1267.3	61.02
775	11/1/2014	12/1/2014	12/31/2039	A	11	85.9599	5	295.39	-209.4301
776	11/1/2014	12/1/2014	5/31/2015	I					
777	11/1/2014	12/1/2014	2/28/2015	I	17	232.45			
778	11/1/2014	12/1/2014	12/31/2039	A	14	575.38			575.38
779	11/1/2014	12/1/2014	5/9/2015	I	13	1008.44			
780	11/1/2014	12/1/2014	12/31/2039	A	13	1083.35	19	2192.73	-1109.38
781	11/1/2014	12/1/2014	12/31/2039	A	6	379.5	11	1225.2	-845.7
782	11/1/2014	12/1/2014	12/31/2039	A	11	682.38	17	1010.04	-327.66
783	11/1/2014	12/1/2014	12/31/2039	A	16	506.18	10	1099.18	-593
784	12/16/2014	1/16/2015	2/28/2015	I	23	261.06			
785	12/16/2014	1/16/2015	12/31/2039	A	17	1206.43	8	1265.78	-59.35

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
786	12/16/2014	1/16/2015	12/31/2039	A	7	246.12			246.12
787	12/16/2014	1/16/2015	12/31/2039	A	15	767.03	20	637.89	129.14
788	12/16/2014	1/16/2015	4/30/2015	I	11	382.82			
789	12/16/2014	1/16/2015	12/31/2039	A	4	264.51	5	222.27	42.24
790	12/16/2014	1/16/2015	12/31/2039	A	6	279.9			279.9
791	12/16/2014	1/16/2015	1/31/2015	I	3	285.16			
792	1/1/2015	2/1/2015	4/30/2015	I	1	148.35			
793	1/1/2015	2/1/2015	12/31/2039	A	3	113.7	2	106.82	6.88
794	1/1/2015	2/1/2015	12/31/2039	A					0
795	1/1/2015	2/1/2015	4/30/2015	I	12	20.2			
796	1/1/2015	2/1/2015	12/31/2039	A	15	1724.15	6	62.14	1662.01
797	1/1/2015	2/1/2015	12/31/2039	A	11	84.01	2	24.18	59.83
798	1/1/2015	2/1/2015	12/31/2039	A	11	357.98	11	191.2	166.78
799	1/1/2015	2/1/2015	12/31/2039	A	8	498.81	9	723.12	-224.31
800	1/1/2015	2/1/2015	7/31/2015	I					
801	1/1/2015	2/1/2015	3/8/2015	I	8	110.5			
802	1/1/2015	2/1/2015	12/31/2039	A	8	392.56	9	1408.91	-1016.35
803	1/1/2015	2/1/2015	12/31/2039	A	10	12	12	15.6	-3.6
804	1/1/2015	2/1/2015	12/31/2039	A	12	156.28	5	101.42	54.86
805	2/1/2015	3/1/2015	12/31/2039	A	3	116.23	4	270.97	-154.74
806	2/1/2015	3/1/2015	12/31/2039	A	16	747.6	13	180.22	567.38
807	2/1/2015	3/1/2015	12/31/2039	A	5	417.17	16	1468.65	-1051.48
808	2/1/2015	3/1/2015	12/31/2039	A	13	822.87	11	106.92	715.95
809	2/1/2015	3/1/2015	12/31/2039	A	14	698.47	9	477.8	220.67
810	2/1/2015	3/1/2015	12/31/2039	A	27	6887.12	24	5322.39	1564.73
811	2/1/2015	3/1/2015	12/31/2039	A	9	167.72	16	186.07	-18.35
812	2/1/2015	3/1/2015	12/31/2039	A	5	173.33	12	2063.63	-1890.3
813	3/1/2015	4/1/2015	12/31/2039	A	2	41.55			41.55
814	3/1/2015	4/1/2015	12/31/2039	A	10	780.77	8	441.39	339.38
815	3/1/2015	4/1/2015	12/31/2039	A	4	180.4	9	923.87	-743.47
816	3/1/2015	4/1/2015	12/31/2039	A	22	1123.91	3	65.34	1058.57
817	3/1/2015	4/1/2015	5/31/2015	I	8	58.65			
818	3/1/2015	4/1/2015	12/31/2039	A	15	356.47	17	326.5299	29.9401
819	3/1/2015	4/1/2015	12/31/2039	A	8	6358.35	8	6978.77	-620.42
820	3/1/2015	4/1/2015	12/31/2039	A	16	1976.51	10	864.76	1111.75
821	4/1/2015	5/1/2015	12/31/2039	A	6	7.2	19	22.8	-15.6
822	4/1/2015	5/1/2015	4/6/2015	I					
823	4/1/2015	5/1/2015	12/31/2039	A	3	62.31	12	812.62	-750.31
824	4/1/2015	5/1/2015	12/31/2039	A	17	49.1599	6	9.6	39.5599
825	4/1/2015	5/1/2015	12/31/2039	A	19	1290.29	8	131.88	1158.41

Number	Month Before Lock-In	Lock-In Date	Term Date	Status	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims July 2015	Total Amount July 2015	Total Savings July 2015
826	4/1/2015	5/1/2015	7/31/2015	I	6	708.52	13	1282.29	
827	4/1/2015	5/1/2015	12/31/2039	A	12	2023.88	10	1140.22	883.66
828	4/1/2015	5/1/2015	12/31/2039	A	19	881.6	8	172.31	709.29
829	5/1/2015	6/1/2015	12/31/2039	A	28	4228.67	17	3315	913.67
830	5/1/2015	6/1/2015	12/31/2039	A	5	433.24	7	448.82	-15.58
831	5/1/2015	6/1/2015	12/31/2039	A	19	379.62	30	567.46	-187.84
832	5/1/2015	6/1/2015	12/31/2039	A	6	92.08	7	357.65	-265.57
833	5/1/2015	6/1/2015	12/31/2039	A	5	124.11	1	155.52	-31.41
834	5/1/2015	6/1/2015	12/31/2039	A	7	10.8	5	8.4	2.4
835	5/1/2015	6/1/2015	12/31/2039	A	5	243.07	7	269.65	-26.58
836	5/1/2015	6/1/2015	12/31/2039	A	7	440.54	7	555.71	-115.17
837	5/1/2015	6/1/2015	12/31/2039	A	18	320.24	6	74.9599	245.2801
838	5/1/2015	6/1/2015	12/31/2039	A	4	61.04	8	219.43	-158.39
839	5/1/2015	6/1/2015	12/31/2039	A	26	4679.61	27	558.83	4120.78
840	5/1/2015	6/1/2015	12/31/2039	A	0	0			0
841	5/1/2015	6/1/2015	12/31/2039	A	8	46.75	11	55	-8.25
842	5/1/2015	6/1/2015	12/31/2039	A	10	786.85	9	909.08	-122.23
843	5/1/2015	6/1/2015	12/31/2039	A	13	1004.57	8	2108.39	-1103.82
844	6/1/2015	7/1/2015	12/31/2039	A	4	5605.12	4	41.07	5564.05
845	6/1/2015	7/1/2015	12/31/2039	A	10	1971.32			1971.32
846	6/1/2015	7/1/2015	12/31/2039	A	4	348.82	8	369.01	-20.19
847	6/1/2015	7/1/2015	12/31/2039	A	1	47.32	1	6	41.32
848	6/1/2015	7/1/2015	12/31/2039	A	10	970.94	8	720.36	250.58
849	6/1/2015	7/1/2015	12/31/2039	A	6	597.86	8	810.22	-212.36
850	6/1/2015	7/1/2015	12/31/2039	A	8	204.87	17	211.23	-6.36
851	6/1/2015	7/1/2015	12/31/2039	A	14	896.62	17	950.12	-53.5
852	6/1/2015	7/1/2015	12/31/2039	A	24	2580.94	14	4542.59	-1961.65
853	6/1/2015	7/1/2015	12/31/2039	A	22	895.65	11	1912.12	-1016.47

MM. Kalydeco® (ivacaftor)

Therapeutic Class: Cystic Fibrosis Agent
Last Reviewed by the DUR Board: July 2, 2014

Kalydeco® (ivacaftor) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   Approval will be given if the following criteria are met and documented:

   a. The recipient is six years of age or older; and

   b. The recipient has a diagnosis of cystic fibrosis; and

   c. There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming the presence of one of the following G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N or S549R gene mutationys.

2. Prior Authorization Guidelines

   a. Prior authorization approval will be for one year.

   b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

Kalydeco Utilization

August 1, 2014 - July 31, 2015

Year/Month	Count of Claims	unt of Members	Pharmacy Paid Amt	Paid Per Claim
201408	2	1	$ 52,239.64	$ 26,119.82
201409	1	1	$ 26,119.82	$ 26,119.82
201410	2	2	$ 52,239.64	$ 26,119.82
201411	1	1	$ 26,119.82	$ 26,119.82
201412	2	2	$ 52,239.64	$ 26,119.82
201501	3	2	$ 78,359.46	$ 26,119.82
201502	1	1	$ 24,378.81	$ 24,378.81
201503	1	1	$ 24,378.81	$ 24,378.81
201504	2	2	$ 48,757.62	$ 24,378.81
201505	1	1	$ 24,378.81	$ 24,378.81
201506	2	2	$ 48,757.62	$ 24,378.81
201507	1	1	$ 24,378.81	$ 24,378.81
Grand Total	**19**	**17**	**$ 482,348.50**	**$ 25,386.76**

DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD
PROPOSED PRIOR AUTHORIZATION CRITERIA

Therapeutic Class: Cystic Fibrosis Transmembrane Conductance Regulator Potentiator
Last Reviewed by the DUR Board: July 2, 2014

Kalydeco® (ivacaftor) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and limitations:

   Approval will be given if the following criteria are met and documented:
   a. The recipient has a diagnosis of cystic fibrosis; and
   b. The recipient is at least two years of age or older.
   c. There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming the presence of one of the following gene mutations: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N or S549R.

2. Prior Authorization Guidelines:
   a. Prior authorization approval will be for one year.

3. Quantity Limitations:
   a. Kalydeco (ivacaftor) tablets: 1 box (56 tablets)/28 days
   b. Kalydeco (ivacaftor) packets: 56 packets/28 days

Therapeutic Class Overview
Cystic Fibrosis Transmembrane Conductance Regulator Potentiator

Therapeutic Class

- **Overview/Summary:** Cystic fibrosis is an autosomal recessive disease caused by mutations in the gene on chromosome seven that encodes the cystic fibrosis transmembrane conductance regulator (CFTR).[1] Normally, the CFTR protein functions as a chloride channel which regulates the activity of other cell-surface chloride and sodium channels. Currently, there are more than 1,300 known possible mutations of the CFTR gene, which are divided into five classes. Class I mutations are characterized by defective protein production, resulting in the complete absence of the CFTR protein, while class II mutations involve defective protein processing. Class III and IV mutations are characterized by diminished channel activity and defective conduction, respectively. Lastly, Class V mutations result in reduced amounts of functional CFTR protein.[2] Mutations in the CFTR gene result in deranged transport of ions which include chloride, sodium and bicarbonate; this may lead to viscous secretions in the respiratory, gastrointestinal and reproductive tract, as well as increased salt content in sweat gland secretions.[1]

  In the United States, cystic fibrosis occurs most commonly in Caucasians, with a prevalence of one in approximately 3,000 people. Typical respiratory manifestations of cystic fibrosis include a persistent and productive cough, hyperinflation of the lung fields on chest radiograph, pulmonary function tests consistent with obstructive airway disease, as well as colonization of the airway with pathogenic bacteria early in life. In terms of the gastrointestinal manifestations, patients experience progressive pancreatic disease in the form of pancreatic insufficiency, pancreatitis and cystic fibrosis -related diabetes. Furthermore, malnutrition due to pancreatic insufficiency may cause rectal prolapse and musculoskeletal disorders. Patients with cystic fibrosis are also at an increased risk of liver disease, infertility, venous thrombosis and nephrolithiasis.[1]

  Kalydeco® (ivacaftor) is a CFTR potentiator Food and Drug Administration (FDA)-approved for the treatment of cystic fibrosis in patients at least two years of age who have one of the following mutations in the CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R. If the patient's genotype is unknown, a FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. Ivacaftor is not effective in patients with cystic fibrosis who are homozygous for the F508*del* mutation in the CFTR gene. As a potentiator of the CFTR protein, ivacaftor facilitates increased chloride transport by potentiating the channel-open probability (or gating) of the CFTR protein.[3] According to the consensus guidelines from the Cystic Fibrosis Foundation, in patients six years of age and older with at least one G551D CFTR mutation, treatment with ivacaftor is strongly recommended to improve lung function and quality of life, as well as to reduce exacerbations.[4] Guidelines do not currently address the use of ivacaftor in children two to six years of age.[4] Ivacaftor tablets are FDA-approved for pediatric patients and adults aged six and older while the oral granules are approved for patients two to less than six years of age. Additionally, ivacaftor oral granules are dosed by weight. Both formulations are given twice daily and with fat-containing foods.[3] There are no generic formulations currently available.

Table 1. Current Medications Available in the Therapeutic Class[3]

Generic (Trade Name)	Food and Drug Administration Approved Indications	Dosage Form/Strength	Generic Availability
Ivacaftor (Kalydeco®)	Treatment of cystic fibrosis in patients two years of age and older who have one of the following mutations in the cystic fibrosis transmembrane conductance regulator gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R	Tablet: 150 mg Oral Granule: 50 mg/pack 75 mg/pack	-

Evidence-based Medicine

- The safety and efficacy of ivacaftor for up to 48 weeks in patients with cystic fibrosis for its Food and Drug Administration-approved indications are supported by randomized and controlled clinical trials.[3,5-7]
- In two placebo-controlled trials (N=213), treatment with ivacaftor in patients with cystic fibrosis and at least one G551D-cystic fibrosis transmembrane conductance regulator (CFTR) mutation significantly increased forced expiratory volume in one second (FEV_1) after 24 weeks, and the significant treatment effect was maintained throughout a total of 48 weeks. In addition, treatment with ivacaftor was associated with significant improvements in respiratory symptoms and significant decreases in sweat chloride concentrations and pulmonary exacerbations in one trial. In both trials patients receiving ivacaftor gained significantly more weight compared to placebo.[6,7]
- According to the labeling information for ivacaftor, the efficacy and safety of ivacaftor in patients with cystic fibrosis with G1244E, G1349D, G178R, G551S, G970R, S1251N, S1255P, S549N, or S549R mutation in the CFTR gene were evaluated in a currently unpublished two-part, randomized, double-blind, placebo-controlled, crossover clinical trial (N=39). For the overall population of the nine mutations studied, treatment with ivacaftor compared to placebo resulted in significant improvement in percent predicted FEV_1, body mass index, and cystic fibrosis respiratory symptom score.[3]
- There is currently a lack of long term data with ivacaftor, and its benefits on mortality are unclear at this time.
- The efficacy of ivacaftor in children two to less than six years of age was extrapolated from efficacy in patients six years of age and older with support from population pharmacokinetic analyses.[3]
    - The safety of ivacaftor in children two to less than six years of age (mean age three years) is derived from a 24-week, open-label, clinical trial in 34 patients. The type and frequency of adverse reactions in this trial were similar to those in patients six years and older.[3]

Key Points within the Medication Class

- According to Current Clinical Guidelines:
    - According to the consensus guidelines from the Cystic Fibrosis Foundation, in patients six years of age and older with at least one G551D cystic fibrosis transmembrane conductance regulator (CFTR) mutation, treatment with ivacaftor is strongly recommended to improve lung function and quality of life, as well as to reduce exacerbations. The clinical guideline does not address the use of ivacaftor in patients with a non-G551D CFTR mutation.[4]
    - Guidelines do not currently address the use of ivacaftor in children two to six years of age.[4]
- Other Key Facts:
    - Ivacaftor is the first and only CFTR potentiator Food and Drug Administration (FDA)-approved for the treatment of cystic fibrosis in patients at least two years of age who have one of the following mutations in the CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R.[3]
    - Ivacaftor is not effective in patients with cystic fibrosis who are homozygous for the F508del mutation in the CFTR gene.[3]
    - Currently, ivacaftor is only available as a branded agent.

References

1. Katkin JP. Cystic fibrosis: Clinical manifestations and diagnosis. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2014 [cited 2014 May]. Available from: http://www.utdol.com/utd/index.do.
2. Katkin JP. Cystic fibrosis: Genetics and pathogenesis. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2014 [cited 2014 May]. Available from: http://www.utdol.com/utd/index.do.
3. Kalydeco® [package insert]. Cambridge (MA): Vertex Pharmaceuticals, Inc.; 2015 Mar.
4. Mogayzel PJ Jr, Naureckas ET, Robinson KA, Mueller G, Hadjiliadis D, Hoag JB, et al. Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. Am J Respir Crit Care Med. 2013 Apr 1;187(7):680-9.
5. Accurso F, Rowe SM, Clancy JP, Boyle MP, Dunitz JM, Durie PR, et al. Effect of VX-770 in persons with cystic fibrosis and the G551D-CFTR *m*utation. N Engl J Med. 2010 Nov;363(21):1991-2003.
6. Ramsey BW, Davies J, McElvaney NG, Tullis E, Bell SC, Drevinek P, et al. A CFTR potentiator in patients with cystic fibrosis and the G551D mutation. N Engl J Med. 2011 Nov;365(18):1663-72.
7. Davies JC, Wainwright CE, Canny GJ, Chilvers MA, Howenstine MS, Munck A, et al. Efficacy and safety of ivacaftor in patients aged 6 to 11 years with cystic fibrosis with a G551D mutation. Am J Respir Crit Care Med. 2013 Jun 1;187(11):1219-25.

I. Anti-Fungal Oncychomycosis (Lamisil®, Sporanox®, Penlac®)

Therapeutic Class: Antifungal Agents
Last Reviewed by the DUR: June 3, 2010

Anti-Fungal Onchomycosis are subject to prior authorization:

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

a. Do not authorize itraconazole if recipient has evidence of ventricular dysfunction.

b. Do not authorize terbinafine if recipient has pre-existing liver disease.

c. Positive KOH stain, positive PAS stain or positive fungal culture and any of the following:

1. Recipient experiencing pain which limits normal activity;

2. Recipient has an iatrogenically-induced or disease associated immunosuppression;

3. Recipient has diabetes; or

4. Recipient has significant peripheral vascular compromise.

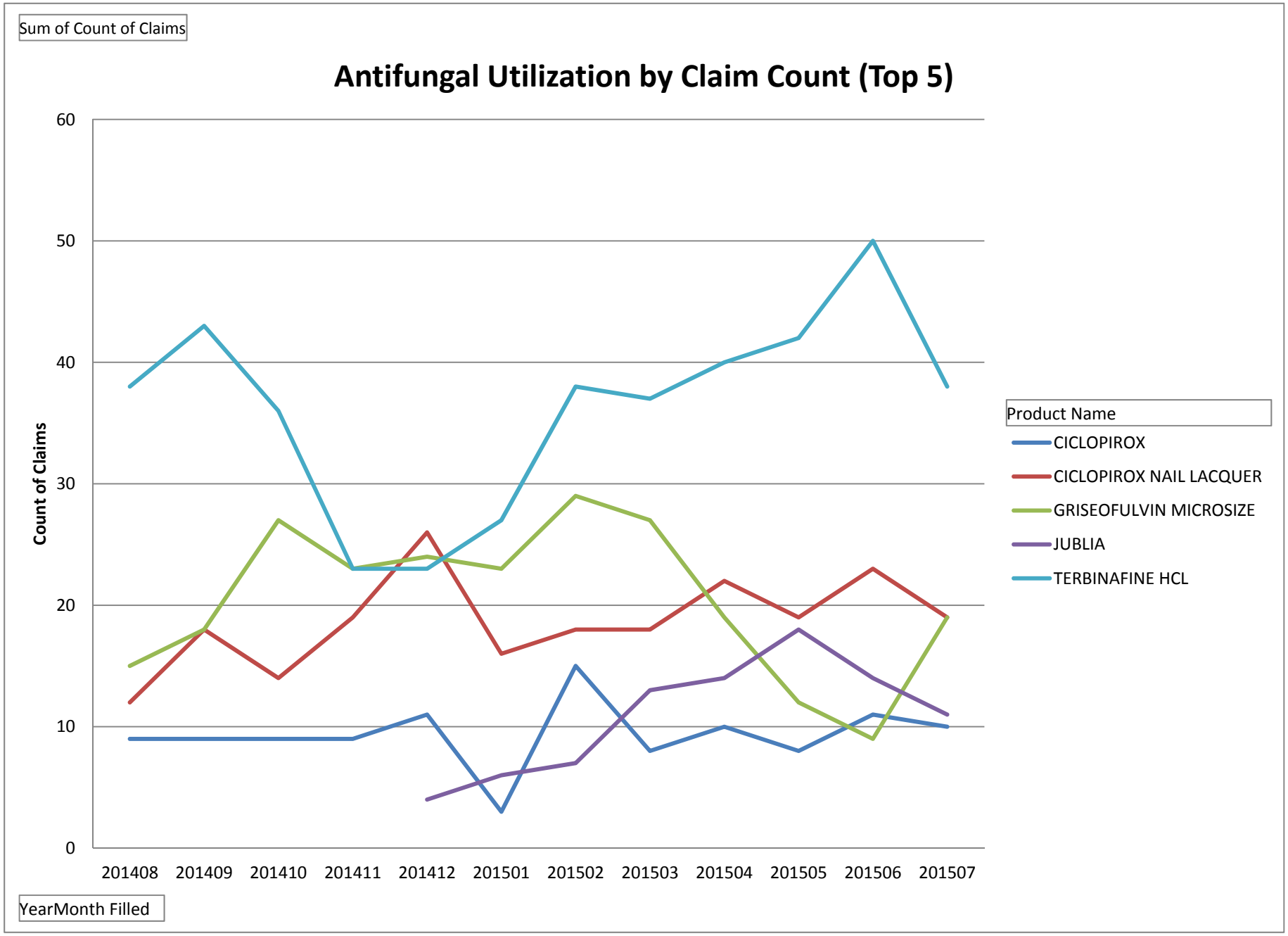
d. Length of Authorization:

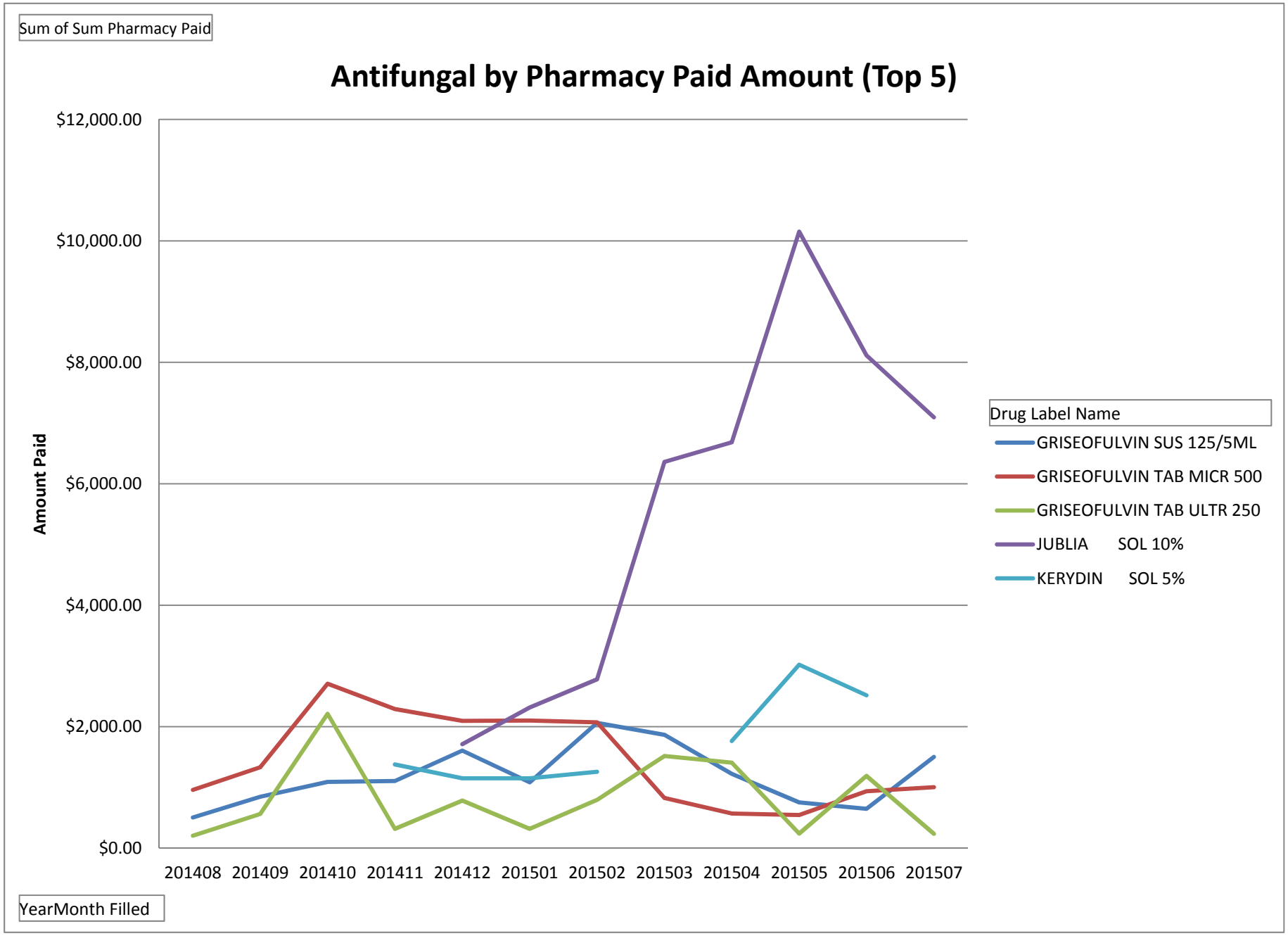
1. Lamisil® tablets & Sporanox® tablets Fingernail: six weeks – Toenail: 12 weeks.

2. Penlac® liquids Initial: three months.

2. Prior Authorization Guidelines

Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms.aspx


Sum of Count of Claims
Antifungal Utilization by Claim Count (Top 5)
Count of Claims
60
50
40
30
20
10
0
201408
201409
201410
201411
201412
201501
201502
201503
201504
201505
201506
201507
YearMonth Filled
Product Name
CICLOPIROX
CICLOPIROX NAIL LACQUER
GRISEOFULVIN MICROSIZE
JUBLIA
TERBINAFINE HCL


Sum of Sum Pharmacy Paid
Antifungal by Pharmacy Paid Amount (Top 5)
$12,000.00
$10,000.00
$8,000.00
$6,000.00
$4,000.00
$2,000.00
$0.00
Amount Paid
201408
201409
201410
201411
201412
201501
201502
201503
201504
201505
201506
201507
YearMonth Filled
Drug Label Name
GRISEOFULVIN SUS 125/5ML
GRISEOFULVIN TAB MICR 500
GRISEOFULVIN TAB ULTR 250
JUBLIA SOL 10%
KERYDIN SOL 5%

Antifungal Utilization

August 1, 2014 - July 31, 2015

Product Name	Drug Label Name	Count of Claims	Count of Members	Pharmacy Paid	Cost/Claim
ATHLETES FOOT AF CREAM	ATHLETE FOOT CRE AF	4	4	$ 49.60	$ 12.40
ATHLETES FOOT AF CREAM Total		**4**	**4**	**$ 49.60**	**$ 12.40**
CICLOPIROX	CICLOPIROX GEL 0.77%	2	2	$ 679.98	$ 339.99
	CICLOPIROX SHA 1%	74	74	$ 8,564.31	$ 115.73
	CICLOPIROX SUS 0.77%	3	2	$ 289.68	$ 96.56
CICLOPIROX Total		**79**	**78**	**$ 9,533.97**	**$ 120.68**
CICLOPIROX NAIL LACQUER	CICLOPIROX SOL 8%	32	32	$ 1,134.50	$ 35.45
CICLOPIROX NAIL LACQUER Total		**32**	**32**	**$ 1,134.50**	**$ 35.45**
CICLOPIROX OLAMINE	CICLOPIROX CRE 0.77%	7	5	$ 475.42	$ 67.92
CICLOPIROX OLAMINE Total		**7**	**5**	**$ 475.42**	**$ 67.92**
GNP TERBINAFINE HYDROCHLO	TERBINAFINE CRE 1%	5	4	$ 60.39	$ 12.08
GNP TERBINAFINE HYDROCHLO Total		**5**	**4**	**$ 60.39**	**$ 12.08**
GRISEOFULVIN MICROSIZE	GRISEOFULVIN SUS 125/5ML	171	164	$ 14,019.23	$ 81.98
	GRISEOFULVIN TAB MICR 500	56	55	$ 14,088.55	$ 251.58
GRISEOFULVIN MICROSIZE Total		**227**	**219**	**$ 28,107.78**	**$ 123.82**
GRISEOFULVIN ULTRAMICROSI	GRISEOFULVIN TAB ULTR 125	8	8	$ 1,385.60	$ 173.20
	GRISEOFULVIN TAB ULTR 250	34	33	$ 9,219.06	$ 271.15
GRISEOFULVIN ULTRAMICROSI Total		**42**	**41**	**$ 10,604.66**	**$ 252.49**
JUBLIA	JUBLIA SOL 10%	79	70	$ 43,217.32	$ 547.05
JUBLIA Total		**79**	**70**	**$ 43,217.32**	**$ 547.05**

Product Name	Drug Label Name	Count of Claims	Count of Members	Pharmacy Paid	Cost/Claim
KERYDIN	KERYDIN SOL 5%	9	9	$ 9,709.14	$ 1,078.79
KERYDIN Total		**9**	**9**	**$ 9,709.14**	**$ 1,078.79**
LAMISIL ADVANCED	LAMISIL ADV GEL 1%	1	1	$ 41.84	$ 41.84
LAMISIL ADVANCED Total		**1**	**1**	**$ 41.84**	**$ 41.84**
LAMISIL AT SPRAY	LAMISIL AT SPR 1%	2	2	$ 23.63	$ 11.82
LAMISIL AT SPRAY Total		**2**	**2**	**$ 23.63**	**$ 11.82**
SM ATHLETES FOOT	ATHLETE FOOT CRE 1%	3	3	$ 34.17	$ 11.39
SM ATHLETES FOOT Total		**3**	**3**	**$ 34.17**	**$ 11.39**
TERBINAFINE HCL	TERBINAFINE CRE 1%	97	95	$ 1,584.16	$ 16.33
	TERBINAFINE TAB 250MG	67	64	$ 632.09	$ 9.43
TERBINAFINE HCL Total		**164**	**159**	**$ 2,216.25**	**$ 13.51**
Grand Total		**654**	**627**	**$ 105,208.67**	**$ 160.87**

DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD
PROPOSED PRIOR AUTHORIZATION CRITERIA

Therapeutic Class: Anti-Fungal Onychomycosis
Last Reviewed by the DUR Board: June 3, 2010

Agents used for the treatment of Onychomycosis are subject to prior authorization.

1. Coverage and limitations:

   Authorization will be given for any agent used for the treatment of onychomycosis (tinea unguium) if the following criteria are met and documented:
   a. The agent is food and drug administration (FDA)-approved for the treatment of onychomycosis (tinea unguium)
      AND
   b. ONE of the following:
      i. Positive KOH stain
      ii. positive PAS stain
      iii. positive fungal culture
      AND
   c. ONE of the following
      i. Recipient is experiencing pain which limits normal activity
      ii. Recipient's disease is iatrogenically-induced
      iii. Recipient's disease is associated with immunosuppression
      iv. Recipient has diabetes
      v. Recipient has significant peripheral vascular compromise
      AND
   d. Requested length of therapy is appropriate based on agent and infection location
      AND
   e. Drug- and/or formulation-specific criteria is met
      i. Terbinafine: no pre-existing liver disease
      ii. Itraconazole: Recipient does not have a diagnosis of heart failure and there is no evidence of ventricular disfunction
      iii. Oral granules dosage form: clinical rational documenting why the recipient cannot or should not use terbinafine tablets or itraconazole capsules.
      iv. Topical dosage forms:
         1. Inadequate response after an appropriate length of therapy with ciclopirox 8% solution OR adverse reaction or contraindication to ciclopirox 8% solution;
            AND
         2. Inadequate response after an appropriate length of therapy to either terbinafine tablets or itraconazole tablets OR adverse reaction or contraindication to terbinafine tablets or itraconazole capsules OR clinical rational why the recipient cannot use terbinafine tablets or itraconazole tablets
      v. Onmel (itraconazole) tablets: clinical rational documenting why the recipient cannot or should not use terbinafine tablets or itraconazole capsules.

2. Prior Authorization Guidelines:
   a. Prior Authorization approval length will be based on appropriate use for individual agents

3. Quantity Limitations:
    a. Terbinafine oral granules: 60 packets/30 days
    b. Efinaconazole topical solution: 1 bottle/30 days
    c. Kerydin: 1 bottle/30 days
    d. Onmel (itraconazole) tablets: 30 tablets/30 days

Therapeutic Class Overview
Onychomycosis Agents

Therapeutic Class

Overview/Summary: This review will focus on the antifungal agents Food and Drug Administration (FDA)-approved for the treatment of onychomycosis.[1-9] Onychomycosis is a progressive infection of the nail bed which may extend into the matrix or plate, leading to destruction, deformity, thickening and discoloration. Of note, these agents are only indicated when specific types of fungus have caused the infection, and are listed in Table 1. Additionally, ciclopirox is only FDA-approved for mild to moderate onychomycosis without lunula involvement.[1] The mechanisms by which these agents exhibit their antifungal effects are varied. For ciclopirox (Penlac®) the exact mechanism is unknown. It is believed to block fungal transmembrane transport, causing intracellular depletion of essential substrates and/or ions and to interfere with ribonucleic acid (RNA) and deoxyribonucleic acid (DNA).[1] The azole antifungals, efinaconazole (Jublia®) and itraconazole tablets (Onmel®) and capsules (Sporanox®) works via inhibition of fungal lanosterol 14-alpha-demethylase, an enzyme necessary for the biosynthesis of ergosterol. By decreasing ergosterol concentrations, the fungal cell membrane permeability is increased, which results in leakage of cellular contents.[2,5,6] Griseofulvin microsize (Grifulvin V®) and ultramicrosize (GRIS-PEG®) disrupts the mitotic spindle, arresting metaphase of cell division. Griseofulvin may also produce defective DNA that is unable to replicate. The ultramicrosize tablets are absorbed from the gastrointestinal tract at approximately one and one-half times that of microsize griseofulvin, which allows for a lower dose of griseofulvin to be administered.[3,4] Tavaborole (Kerydin®), is an oxaborole antifungal that interferes with protein biosynthesis by inhibiting leucyl-transfer ribonucleic acid (tRNA) synthase (LeuRS), which prevents translation of tRNA by LeuRS.[7] The final agent used for the treatment of onychomycosis, terbinafine hydrochloride (Lamisil®), is an allylamine antifungal. While its mechanism is not known, it is asserted it probably exerts its effect by inhibiting the fungal enzyme squalene monooxygenase, which creates a deficiency in ergosterol, a component of fungal membranes necessary for normal growth.[8]

Table 1. Current Medications Available in the Therapeutic Class[1-8]

Generic (Trade Name)	Food and Drug Administration-Approved Indications	Dosage Form/Strength	Generic Availability
Ciclopirox (Penlac®)	Mild to moderate onychomycosis† of the finger or toenail without lunula involvement	Topical solution: 8%	-
Efinaconazole (Jublia®)	Onychomycosis† of the toenail	Topical solution: 10%	-
Griseofulvin microcrystalline (Grifulvin V®*)	Onychomycosis† of the finger or toenail; tinea corporis, tinea pedis, tinea cruris, tinea barbae, tinea capitis	Oral Suspension: 125 mg/5 mL Tablet: 500 mg	a
Griseofulvin ultramicrocrystalline (GRIS-PEG®*)	Onychomycosis† of the finger or toenail; tinea corporis, tinea pedis, tinea cruris, tinea barbae, tinea capitis	Tablet: 125 mg 250 mg	a
Itraconazole (Onmel®, Sporanox®*)	Onychomycosis† of the finger‡ or toenail§, Blastomycosis‡, Histoplasmosis‡, Aspergillosis‡	Capsule: 100 mg Tablet: 200 mg	a
Tavaborole (Kerydin®)	Onychomycosis† of the toenail	Topical solution: 5%	-
Terbinafine hydrochloride (Lamisil®*)	Onychomycosis† of the finger¶ or toenail¶	Tablet: 250 mg	a

*Generic available in at least one dosage form or strength
†Caused by Trichophyton rubrum (ciclopirox); caused by trichophyton rubrum and Trichophyton mentagrophytes (efinaconazole, itraconazole [Onmel®], tavaborole); caused by Trichophyton rubrum, Trichophyton tonsurans, Trichophyton mentagrophytes, Trichophyton interdigitalis, Trichophyton verrucosum, Trichophyton megnini, Trichophyton gallinae, Trichophyton crateriform, Trichophyton sulphureum, Trichophyton schoenleinii, Microsporum audouini, Microsporum canis, Microsporum gypseum and Epidermophyton floccosum (griseofulvin); causative pathogens not reported for itraconazole (Sporanox®) or terbinafine
‡Sporanox® tablets only
§Onmel® and Sporanox® tablets only
¶Lamisil® tablets only

Evidence-based Medicine

- Older agents such as itraconazole, griseofulvin and terbinafine HCl have been well studied. In head-to-head studies, terbinafine HCl and itraconazole provided an improved cure rate over griseofulvin microsize and ultramicrosize tablets.[9-13]
- Studies comparing terbinafine HCl to itraconazole have reported inconsistent results with numerous clinical trials reporting improved clinical and/or mycological cure rates with terbinafine HCl while several published studies have shown no difference between the agents.[13-28]
- The safety and efficacy of ciclopirox nail lacquer topical solution has been evaluated in two double-blind placebo-controlled trials which lasted for 48 weeks each. Both studies showed a significant improvement in mycological cure and culture results for ciclopirox compared with placebo (P<0.001 for both outcomes in both studies).[29]
- The safety and efficacy of once daily use of efinaconazole topical solution for the treatment of onychomycosis of the toenail were assessed in two 52-week vehicle-controlled study. The efinaconazole group had complete cure rates of 17.8% and 15.2% of compared to 3.3% and 5.5% in the vehicle group (P<0.001).[30]
- Itraconazole tablets were approved based on one 12 week, randomized, controlled study in patients with onychomycosis. It was compared to itraconazole capsules and placebo. At week-52, 22.3% of patients in the itraconazole tablets group had complete cure compared to 1.0% in the placebo group (P value not reported). The mycological and clinical cure rates were 44% and 6% and 26% and 3% in the itraconazole tablets and placebo groups, respectively (P value not reported). Efficacy results comparing itraconazole to itraconazole capsules were found to be similar (P value not reported).[5,31]
- The safety and efficacy of tavaborole for the treatment of onychomycosis of the toenail was assessed in two 52-week randomized controlled trials compared with vehicle solution. Complete cure rates in the two studies for tavaborole were 6.5% and 9.1% compared with 0.5% and 1.5% for the vehicle group. A greater proportion of patients in the tavaborole-treated groups experienced mycological cure and complete or almost complete cure compared to vehicle-treated groups (P values not reported).[5]

Key Points within the Medication Class

- Treatment guidelines for onychomycosis infections have not been updated recently, with the last update being in 2005.[32,33]
- According to Clinical Guidelines:[32,33]
    - Oral therapy is more effective, and should be utilized in more serious cases.
    - Combination therapy with an oral and topical agent may be useful in the more severe cases.
    - Oral terbinafine or itraconazole is recommended over griseofulvin due to a much higher cure rate.
    - Neither guideline mentions newer agents as they were not FDA-approved at the time of publication
- Other Key Facts:[1-8]
    - Treatment with topical therapy is longer than oral therapy. Oral therapy with terbinafine HCl or itraconazole is six to 12 weeks depending on indication compared with upwards of 48 weeks with topical therapies.
    - Limited systemic absorption with the topical agents provides reduced adverse effects, usually limited to local reactions.
    - Oral therapy is associated with more side effects and drug interactions that may limit use.

- In addition to a black-box warning for drug interactions, itraconazole has a black-box warning regarding its use in patients with congestive heart failure, which may have a negative inotropic effect.
- Itraconazole tablets (Onmel®) does not provide any clinical advantage over the generic 100 mg capsules other than reduced pill burden.
- Ciclopirox and griseofulvin are approved in pediatric patients (age ≥12 years and ≥2 years, respectively).
- No dosage adjustment is required for any renal or hepatic impairment for any agent; however, terbinafine HCl is not recommended in patients with creatinine clearance (CrCl) <50 mL/min.
- Terbinafine HCl and ciclopirox are pregnancy category B, while griseofulvin is X. Itraconazole, efinaconazole and tavaborole are listed as pregnancy category C; however, itraconazole tablets and capsules are contraindicated in pregnant patients or to women contemplating pregnancy.
- Other formulations of itraconazole (oral solution, Sporanox®), terbinafine HCl (granules, Lamisil®) and ciclopirox (gel, cream, lotion, suspension and shampoo) do not carry an FDA-approved indication for onychomycosis.
- Only griseofulvin microcrystalline, griseofulvin ultramicrocrystalline and terbinafine HCl are available generically.

References

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4. GRIS-PEG® [package insert]. Farmingdale (NY): Pedinol Pharmacal Inc., 2010 Nov.
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V. Sedative Hypnotics

Therapeutic Class:
Last Reviewed by the DUR Board:

Sedatives Hypnotics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

Sedative/Hypnotic Utilization

August 1, 2014 - July 31, 2015

Ages 0-18

Drug Name	Count of Claims	Pharmacy Paid	Cost/Claim
LORAZEPAM	365	$ 4,162.60	$ 11.40
DIAZEPAM	351	$ 4,861.80	$ 13.85
ALPRAZOLAM	190	$ 1,374.76	$ 7.24
ZOLPIDEM TARTRATE	88	$ 505.58	$ 5.75
TEMAZEPAM	78	$ 3,058.19	$ 39.21
CLORAZEPATE DIPOTASSIUM	16	$ 392.79	$ 24.55
TRIAZOLAM	5	$ 25.64	$ 5.13
DIAZEPAM INTENSOL	5	$ 221.35	$ 44.27
ALPRAZOLAM INTENSOL	3	$ 317.67	$ 105.89
ROZEREM	2	$ 577.30	$ 288.65
CHLORDIAZEPOXIDE HCL	1	$ 5.92	$ 5.92
ZOLPIDEM TARTRATE ER	1	$ 80.78	$ 80.78
ALPRAZOLAM ER	1	$ 59.54	$ 59.54
ALPRAZOLAM ODT	1	$ 18.47	$ 18.47
Grand Total	**1,107**	**$ 15,662.39**	**$ 14.15**

Ages >18

Drug Name	Count of Claims	Pharmacy Paid	Cost/Claim
ALPRAZOLAM	33,401	$ 297,531.75	$ 8.91
ZOLPIDEM TARTRATE	17,005	$ 97,357.91	$ 5.73
DIAZEPAM	11,136	$ 64,688.02	$ 5.81
LORAZEPAM	9,461	$ 73,777.05	$ 7.80
TEMAZEPAM	6,754	$ 93,265.17	$ 13.81
CHLORDIAZEPOXIDE HCL	506	$ 3,962.51	$ 7.83
TRIAZOLAM	442	$ 6,774.63	$ 15.33
ZOLPIDEM TARTRATE ER	323	$ 41,056.44	$ 127.11
ROZEREM	322	$ 73,896.66	$ 229.49
ESZOPICLONE	264	$ 12,826.02	$ 48.58
FLURAZEPAM HCL	161	$ 1,306.48	$ 8.11
ALPRAZOLAM ER	154	$ 7,221.32	$ 46.89
CLORAZEPATE DIPOTASSIUM	107	$ 1,475.01	$ 13.79
ZALEPLON	47	$ 613.22	$ 13.05
ALPRAZOLAM XR	45	$ 2,146.36	$ 47.70
BELSOMRA	37	$ 9,659.40	$ 261.06
XANAX	35	$ 14,916.82	$ 426.19
OXAZEPAM	27	$ 985.21	$ 36.49
AMBIEN	24	$ 8,974.71	$ 373.95
ALPRAZOLAM ODT	20	$ 4,004.31	$ 200.22
MAPAP PM	15	$ 89.10	$ 5.94
SONATA	12	$ 2,347.11	$ 195.59
LUNESTA	10	$ 3,651.06	$ 365.11
ESTAZOLAM	8	$ 154.18	$ 19.27
ATIVAN	7	$ 15,940.65	$ 2,277.24
SILENOR	6	$ 1,911.69	$ 318.62
XANAX XR	6	$ 2,959.68	$ 493.28
LORAZEPAM INTENSOL	3	$ 104.28	$ 34.76
Grand Total	**80,338**	**$ 843,596.75**	**$ 10.50**

DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD
PROPOSED PRIOR AUTHORIZATION CRITERIA

V. Sedative Hypnotics
Therapeutic Class: Psychotropics (sedative hypnotics)
Last Reviewed by the DUR Board:

Sedatives Hypnotics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity

1. Criteria:
    a. Food and Drug Administration (FDA)-approved diagnosis
        i. Hetlioz (tasimelteon): a diagnosis of non-24-hour sleep-wake disorder
        ii. All other agents: insomnia

2. Quantity Limitations:
    a. Sedative/Hypnotics, Non-Barbiturate: 30 tabs/30 days
        i. Rozerem (ramelteon)
        ii. Hetlioz (tasimelteon)
        iii. Silenor (doxepin)
        iv. Belsomra (suvorexant)
        v. Ambien, Intermezzo, Edluar (zolpidem)
        vi. Ambien CR (zolpidem ER)
        vii. Sonata (zaleplon)
        viii. Doral (quazepam)
        ix. Halcion (temazepam)
        x. estazolam
        xi. flurazepam
    b. Midazolam (solution for injection): 100 mL/day
    c. Midazolam (syrup): 10 mL/day
    d. Zolpimist (zolpidem) spray: 1 unit/30 days

Therapeutic Class Overview
Sedative Hypnotics

Therapeutic Class

- **Overview/Summary:**

Insomnia is the most common sleep disorder in adulthood, affecting 33 to 69% of the population. It is estimated that five to ten percent of adults experience specific insomnia disorders.[1,2] Insomnia is a disorder that results from a difficulty in initiating or maintaining sleep, waking too early, or sleep that is considered nonrestorative or poor quality.[1-3] Furthermore, individuals with insomnia must also report at least one of the following types of daytime impairment as a result of the difficulties experienced with sleep: fatigue/malaise; impairment in memory, attention, or concentration; social or work-related dysfunction; poor school performance; irritability; day time sleepiness; loss of motivation, energy, or initiative; increased tendency for work or driving related accidents/errors; tension headaches; gastrointestinal symptoms; or concerns/worries about sleep. In individuals with insomnia, these complaints occur despite having sufficient opportunity and circumstances for sleep.[1,2] According to the International Classification of Sleep Disorders, insomnia may be classified as one of the following: short-term insomnia, chronic insomnia or other insomnia (defined as patients who experience difficulty initiating or maintaining sleep but do not meet all of the criteria for either short-term or chronic insomnia).[2]

There are several classes of medications available for the management of insomnia.[4-6] Doxepin (Silenor®) is a tricyclic antidepressant that is Food and Drug Administration (FDA)-approved for the treatment of insomnia characterized by difficulties with sleep maintenance. The exact mechanism by which doxepin exerts its therapeutic effect on insomnia has not been elucidated; however, it is most likely due to antagonism of the histamine-1 receptor.[7] Ramelteon (Rozerem®) is a melatonin agonist that binds to melatonin receptors with much higher affinity compared to melatonin.[8] Similar to ramelteon, tasimelteon (Hetlioz®) is also a melatonin agonist and it is indicated for the treatment non-24 hour sleep-wake disorder, a disorder that is characterized by the extension of the natural sleep-wake cycle beyond 24 hours.[9] Suvorexant (Belsomra®) belongs to a novel class of orexin receptor antagonists and is thought to suppress the wake-drive by blocking the binding of wake-promoting neuropeptides.[10] Doxepin, ramelteon, tasimelteon and suvorexant are not available generically; however; doxepin is available generically in higher doses that are approved for the treatment of depression and anxiety.[6] Benzodiazepines relieve insomnia by reducing sleep latency and increasing total sleep time. Benzodiazepines increase stage two sleep while decreasing rapid eye movement sleep, stage three and stage four sleep.[5] The benzodiazepines bind to γ-aminobutyric acid subtype A ($GABA_A$) receptors in the brain, thereby stimulating GABAergic transmission and hyperpolarization of neuronal membranes.[5] The benzodiazepines primarily differ in their duration of action. Triazolam (Halcion®) has a short duration of action, while estazolam (ProSom®) and temazepam (Restoril®) are intermediate-acting agents. Flurazepam (Dalmane®) and quazepam (Doral®) are generally considered long-acting benzodiazepines.[11-15] All of the benzodiazepines are available generically with the exception of quazepam.[6] The nonbenzodiazepine sedative hypnotics are structurally distinct from the benzodiazepines resulting in more specific activity at the $GABA_A$ receptor. As a result, the nonbenzodiazepine sedative hypnotics are associated with less anxiolytic and anticonvulsant activity compared to the benzodiazepines.[4] Zaleplon (Sonata®) has a duration of approximately one hour, and thus is an effective treatment for patients with difficulty falling asleep.[16] Zolpidem has a duration of less than two and a half hours and may also be useful for patients with difficulties initiating sleep. Zolpidem is available in as an immediate-release tablet (Ambien®), oral spray (Zolpimist®), sublingual tablet (Edluar® and Intermezzo®) and extended-release tablet (Ambien CR®). The sublingual tablet (Intermezzo®) is the only zolpidem formulation that is approved for the treatment of insomnia due to middle-of-the-night awakenings.[17-21] Of the nonbenzodiazepine sedative hypnotics, eszopiclone (Lunesta®) has the longest half-life (approximately five to seven hours); therefore it is effective in treating sleep onset insomnia and sleep maintenance insomnia.[22] Currently zaleplon, eszopiclone and zolpidem (immediate-release and extended-release tablets) are available generically.[6]

Table 1. Current Medications Available in the Therapeutic Class[7-21]

Generic (Trade Name)	Food and Drug Administration Approved Indications	Dosage Form/Strength	Generic Availability
Doxepin (Silenor®)	Treatment of insomnia characterized by difficulties with sleep maintenance	Tablet: 3 mg 6 mg	-
Estazolam (ProSom®*)	Short-term treatment of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings, and/or early morning awakenings	Tablet: 1 mg 2 mg	a
Eszopiclone (Lunesta®)	Treatment of insomnia	Tablet: 1 mg 2 mg 3 mg	-
Flurazepam (Dalmane®*)	Treatment of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings, and/or early morning awakenings	Capsule: 15 mg 30 mg	a
Quazepam (Doral®)	Treatment of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings, and/or early morning awakenings	Tablet: 15 mg	-
Ramelteon (Rozerem®)	Treatment of insomnia characterized by difficulty with sleep onset	Tablet: 8 mg	-
Suvorexant (Belsomra®)	Treatment of insomnia characterized by difficulties with sleep onset and/or sleep maintenance	Tablet: 5 mg 10 mg 15 mg 20 mg	-
Tasimelteon (Hetlioz®)	Treatment of non-24-hour sleep-wake disorder	Capsule: 20 mg	-
Temazepam (Restoril®*)	Short-term treatment of insomnia	Capsule: 7.5 mg 15 mg 22.5 mg 30 mg	a
Triazolam (Halcion®*)	Short-term treatment of insomnia	Tablet: 0.125 mg 0.25 mg	a
Zaleplon (Sonata®*)	Short-term treatment of insomnia	Capsule: 5 mg 10 mg	a
Zolpidem (Ambien®*, Ambien CR®*, Edluar®, Intermezzo®, Zolpimist®)	Short-term treatment of insomnia characterized by difficulties with sleep initiation†, treatment of insomnia characterized by difficulties with sleep onset and/or sleep maintenance‡, treatment of insomnia when a middle-of-the-night awakening is followed by difficulty returning to sleep§	Extended-release tablet: 6.25 mg 12.5 mg Immediate-release tablet: 5mg 10 mg Sublingual tablet: 5 mg* 10 mg* 1.75 mg†	a

Generic (Trade Name)	Food and Drug Administration Approved Indications	Dosage Form/Strength	Generic Availability
		3.5 mg† Oral mist: 5 mg/ actuation	

*Generic available in at least one dosage form or strength.
†Ambien® (zolpidem), Edluar® (zolpidem sublingual), and Zolpimist® (zolpidem oral mist).
‡ Intermezzo® (zolpidem sublingual).
§ Ambien CR® (zolpidem extended-release).

Evidence-based Medicine

- The result of clinical studies consistently demonstrate that the sedative hypnotics are more effective compared to placebo in patients experiencing insomnia.[22-84]
- The result of several meta-analyses have demonstrated that the benzodiazepine significantly improve sleep latency and total sleep time in patients with insomnia.[77,78,80,81,84]
- Some studies indicate that zaleplon may result in less residual effects and rebound insomnia when compared to zolpidem.[63,65]
- Several agents have demonstrated efficacy in the presence of various comorbidities or specific subpopulations. Eszopiclone and ramelteon have been found to be beneficial across multiple symptoms, including sleep disturbances, mood disturbances, anxiety and hot flashes in peri- and postmenopausal women.[55,35] Eszopiclone has also been found to improve sleep-related symptoms in patients with depression, Parkinson disease, and post-traumatic stress disorder.[29,32,33] Ramelteon has demonstrated efficacy in patients with comorbid generalized anxiety disorder and also in patients with substance abuse.[41,57] Zolpidem extended-release has demonstrated efficacy, when coadministered with escitalopram, in patients with both major depressive disorder as well as generalized anxiety disorder.[70,71] Zolpidem and zaleplon have both demonstrated safety and efficacy in patients with nonpsychotic psychiatric disorders.[66] Efficacy has also been established in populations of elderly patients. Doxepin has demonstrated safety and efficacy in elderly patients through 12 weeks, without causing residual sedation or increasing the risk of complex sleep behaviors.[24,28] Eszopiclone has demonstrated safety and efficacy over two weeks in elderly patients and ramelteon over five weeks.[36,50]
- Furthermore, efficacy of the Furthermore, efficacy of the non-benzodiazepine hypnotics has been demonstrated to be sustained for up to one year. Eszopiclone and zolpidem extended-release have demonstrated sustained efficacy through six months while ramelteon and zolpidem immediate-release have demonstrated sustained efficacy over the course of a year.[30,37,38,56,69,76]

Key Points within the Medication Class

- According to Current Clinical Guidelines:
  - Guidelines do not recommend one sedative hypnotic over another.[1]
  - All agents have been shown to result in positive effects on sleep latency, total sleep time and wake time after sleep onset. Selection of an agent should take into consideration the patient's specific symptom pattern, patient preferences, any comorbid disease states and concurrent medications, as well as the individual side effect profile for each option. Zaleplon and ramelteon have short half-lives, work well to reduce sleep latency and are unlikely to result in residual sedation; however, they have little effect on waking after sleep onset.[1]
  - Eszopiclone and temazepam have longer half-lives, are more likely to improve sleep maintenance, and are more likely to produce residual sedation.[1]
  - Triazolam has been associated with rebound anxiety and is not considered a first-line treatment.[1]
  - The use of doxepin for insomnia in the absence of co-morbid depression is not addressed in clinical guidelines, as the low-dose formulation was not available when these guidelines were published.[1]

- Depending on the patient's specific complaint of sleep initiation or sleep maintenance, consideration should be given to the pharmacokinetic parameters of the available hypnotics. Agents with a longer half-life may be preferred in those with sleep maintenance issues, while agents with a shorter time to maximum concentration may be preferred in patients with sleep initiation complaints. If a patient does not respond to the initial agent, a different agent within the same class is appropriate after evaluating the patient's response to the first agent.[1]

Other Key Facts:

- Currently, estazolam, eszopiclone, flurazepam, temazepam, triazolam, zaleplon and zolpidem (immediate-release and extended-release tablets) are available generically.[6]
- However; doxepin is available generically in higher doses that are approved for the treatment of depression and anxiety.[6]

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Corlanor Utilization

August 1, 2014 - July 31, 2015

Row Labels	Count of Claims	Count of Members	Pharmacy Paid
201506	1	1	$ 387.26
CORLANOR	1	1	$ 387.26
Grand Total	**1**	**1**	**$ 387.26**

DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD
PROPOSED PRIOR AUTHORIZATION CRITERIA

Therapeutic Class: Corlanor (ivabradine)
Last Reviewed by the DUR Board:

Corlanor (ivabradine) is subject to prior authorization.

1. Coverage and limitations:

   Authorization will be given if the following criteria are met and documented:
   a. Diagnosis of chronic heart failure
      AND
   b. Left ventricular ejection fraction (LVEF) ≤ 35%
      AND
   c. Resting hear rate ≥ 70 bpm
      AND
   d. Member is ≥ 18 years of age
      AND
   e. Prescriber is a cardiologist or there is documentation in the recipient's medical record that a cardiologist has been consulted regarding the diagnosis and treatment recommendations
      AND
   f. The recipient is in normal sinus rhythm
      AND
   g. The recipient is on a maximally tolerated dose of a beta-blocker or the recipient has a contraindication to beta-blocker use
      AND
   h. The requested dose does not exceed 60 tablets/30 days

2. Prior Authorization Guidelines:
   a. Prior Authorization approval length will be based on appropriate use for individual agents

3. Quantity Limitations:
   a. Corlanor (ivabradine): 60 tablets/30 days

New Drug Overview
Corlanor® (Ivabradine)

Overview/Summary: Corlanor® (ivabradine) is a novel medication that received priority review designation from the Food and Drug Administration (FDA) and was granted fast track designation for patients with systolic heart failure (HF) who receive standard therapy and who have an elevated heart rate of 70 beats per minute (bpm) or greater.[1] It was approved to reduce the risk of hospitalization for worsening HF in adult patients who are either on maximally tolerated doses of β-blockers or have a contraindication to β-blocker use. This agent works by blocking the hyperpolarization-activated cyclic nucleotide-gated (HCN) channel responsible for the cardiac pacemaker I_f, which regulates heart rate. This results in heart rate reduction with no effect on ventricular repolarization or myocardial contractility.[2]

Heart failure affects more than five million adults in the U.S. and its prevalence is projected to increase by 25% by 2030.[3] The presence of multiple comorbidities poses significant challenges in the treatment and management of patients with HF. Atherosclerotic disease, diabetes, metabolic syndrome, obesity and uncontrolled hypertension are some of the predisposing risk factors for HF. Heart failure is a clinical syndrome caused by the inability of the heart to pump sufficient blood to meet the demands of the body. It can result from a number of cardiac diseases including those that reduce ventricular filling (diastolic dysfunction) and or myocardial contractility (systolic dysfunction). The cardinal manifestations of HF are dyspnea, fatigue and fluid retention.[4] Goals of HF therapy are clinical improvement of symptoms and ultimately a reduction in the risk of morbidity (including the rate of hospitalization) and mortality. Generally, loop diuretics are initiated first in individuals with overt HF to assist with fluid control. A β-blocker, an angiotensin converting enzyme inhibitor (ACEI) or angiotensin II receptor blocker (ARB), and an aldosterone antagonist are the preferred antihypertensive agents as they have been shown to improve survival in patients with HF. For those who cannot tolerate these drugs, appropriate alternative agents include nitrates, some vasoselective calcium channel blockers (e.g., amlodipine and felodipine), and hydralazine.[5] Resting heart rate is a significant independent predictor of poor outcomes in patients with chronic symptomatic HF. Evidence suggests that cardiovascular (CV) risk associated with heart rate rises steeply at resting heart rates of 70 bpm and greater.[6] There are currently limited treatment options for those individuals with chronic HF whose symptoms are not controlled with guideline-recommended treatment leading to frequent hospitalizations.[7]

Table 1. Dosing and Administration

Generic Name (Trade Name)	FDA-Approved Indications	Pediatric Dose	Availability
Ivabradine	Chronic heart failure: Tablet: Initial, 5 to 60 mg QD with food*; maintenance, use lowest dosage that will maintain an adequate clinical response; maximum, undefined†	Safety and efficacy in children have not been established.	Tablet: 5 mg 7.5 mg

Evidence-based Medicine

- The approval of ivabradine was based mainly on global clinical data from a phase III, multicenter, randomized, double-blind, parallel-group, placebo-controlled SHIFT trial in 6,558 clinically stable patients in sinus rhythm with reduced left ventricular ejection fraction (LVEF) ≤ 35%, heart rate (HR) ≥ 70 bpm, and with a hospitalization for HF within the past 12 months.
    - Ivabradine significantly reduced the risk of hospitalization or cardiovascular death for worsening HF, with 672 (21%) of patients on placebo compared to 514 (16%) of those on ivabradine experiencing a hospital admission (hazard ration [HR], 0.74; 95% confidence interval [CI], 0.66 to 0.83; P<0.0001).
    - There was no favorable effect on the mortality component of the primary endpoint.

- CV deaths in the overall treatment group were not significantly reduced by ivabradine (P=0.128), but deaths due to HF did decrease significantly (HR, 0.74; 95% CI, 0.58 to 0.94; P=0.014).[9]

· Two additional double-blind, multi-center, placebo-controlled phase III trials evaluated the use of ivabradine compared to placebo in individuals with coronary artery disease (CAD).
  - The BEAUTIFUL study that ivabradine did not affect CV death or admission to hospital for MI or new-onset or worsening HF (HR, 1.00; 95% CI, 0.91 to 1.10; P=0.94) and there was no statistical significance seen with the ivabradine group compared to placebo for any of the mortality endpoints.[10]
  - The third phase III trial, SIGNIFY, evaluated the use of ivabradine compared to placebo in individuals with stable coronary artery disease but without clinically significant HF. There was no significant effect of ivabradine on the composite of death from CV causes or nonfatal MI or secondary endpoint of death from CV causes, nonfatal MI and death from any cause.[11]

Key Points

· According to Current Clinical Guidelines:
  - Consensus guidelines in the U.S. have not been updated to address this medication's place in therapy. However, the European Society of Cardiology (ESC) and the National Institute for Health Care Excellence (NICE) guidelines have both provided recommendations for the use of this agent in chronic HF.[7]
  - The 2013 guidelines from the American College of Cardiology Foundation/American Heart Association continue to recommend that all individuals with hypertension and lipid disorders should be controlled according to contemporary guidelines to lower the risk of HF.[8]
  - Specifically in Stage B-D HF with reduced ejection fraction, individuals should be given an ACE inhibitor to prevent symptomatic HF and reduce mortality (or an ARB if ACE inhibitor is contraindicated).[8]
  - In patients with a recent or remote history of myocardial infarction (MI) or acute coronary syndrome (ACS) and reduced ejection fraction (EF), a β-blocker such as bisoprolol, carvedilol or sustained-release metoprolol succinate, is recommended for all patients.[8]
  - In the case of volume overload, in New York Heart Association (NYHA) class II-IV patients, it is recommended to add a diuretic, unless contraindicated, to improve symptoms (loop diuretics are preferred).[8]
  - Other alternatives such as the combination of hydralazine and isosorbide dinitrate can be considered for those who cannot be given an ACEI or ARB because of drug intolerance, hypotension or renal insufficiency, unless contraindicated.[8]
  - Aldosterone receptor antagonists are also recommended to reduce morbidity and mortality following an acute MI in patients with a LVEF ≤ 40% who develop symptoms of HF or who have a history of diabetes mellitus, unless contraindicated.[8]

· Other Key Facts:
  - Ivabradine has a novel mechanism of action.
  - Ivabradine provides an alternative treatment option for individuals with chronic HF who cannot take β-blockers as part of their SOC regimen or as an adjunct treatment for those individuals not adequately treated with maximally tolerated doses of β-blockers and other SOC medications.
  - Ivabradine is only approved for a small subset of chronic HF individuals.
  - Ivabradine has not shown to provide a decreased risk of cardiovascular mortality.[9]
  - As noted in the product dossier, the results from the SIGNIFY Study are not directly applicable to the evaluation of benefit-risk in the chronic HF population as this study did not enroll any individuals with NYHA class II or greater.

References

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Count of Recipients on Insulin without Monitoring

August 1, 2014 - July 31, 2015

Row Labels	Count of Member ID
NVMBASIC	**4508**
LANTUS INJ SOLOSTAR	1223
LANTUS INJ 100/ML	781
HUMALOG KWIK INJ 100/ML	425
HUMALOG INJ 100/ML	303
NOVOLOG INJ FLEXPEN	302
LEVEMIR INJ FLEXTOUC	285
NOVOLOG INJ 100/ML	189
LEVEMIR INJ	130
HUMULIN R INJ U-100	114
HUMULIN N INJ U-100	79
NOVOLOG MIX INJ FLEXPEN	72
NOVOLIN INJ 70/30	70
LEVEMIR INJ FLEXPEN	64
NOVOLIN N INJ RELION	58
APIDRA INJ SOLOSTAR	56
HUMULIN INJ 70/30	48
HUMALOG MIX INJ 75/25KWP	48
NOVOLIN R INJ RELION	39
NOVOLIN R INJ U-100	31
HUMALOG MIX INJ 50/50KWP	29
NOVOLIN70/30 INJ RELION	29
APIDRA INJ U-100	26
NOVOLOG MIX INJ 70/30	25
NOVOLIN N INJ U-100	22
HUMULIN R INJ U-500	20
HUMULIN INJ 70/30KWP	13
HUMALOG MIX SUS 75/25	11
NOVOLOG INJ PENFILL	7
HUMULIN N INJ U-100KWP	7
TOUJEO SOLO INJ 300IU/ML	1
AFREZZA POW 4UNIT	1
NVMLTC	**721**
NOVOLOG INJ FLEXPEN	247
LANTUS INJ SOLOSTAR	78
LANTUS INJ 100/ML	71
LEVEMIR INJ FLEXTOUC	52
HUMALOG KWIK INJ 100/ML	51
HUMALOG INJ 100/ML	37
LEVEMIR INJ	35
NOVOLOG INJ 100/ML	33
NOVOLOG MIX INJ FLEXPEN	24
NOVOLIN R INJ U-100	21
HUMULIN R INJ U-100	20

LEVEMIR INJ FLEXPEN	17
NOVOLIN R INJ RELION	12
NOVOLIN70/30 INJ RELION	11
NOVOLIN N INJ U-100	9
NOVOLIN N INJ RELION	2
HUMULIN N INJ U-100	1
NVMBASICP	**35**
LANTUS INJ 100/ML	7
HUMALOG KWIK INJ 100/ML	6
NOVOLOG INJ 100/ML	5
HUMALOG INJ 100/ML	5
HUMULIN N INJ U-100KWP	3
LANTUS INJ SOLOSTAR	3
NOVOLIN R INJ U-100	1
NOVOLOG INJ FLEXPEN	1
APIDRA INJ U-100	1
NOVOLIN N INJ RELION	1
LEVEMIR INJ FLEXTOUC	1
NOVOLIN N INJ U-100	1
NVMBASICCU	**10**
LANTUS INJ SOLOSTAR	4
NOVOLOG INJ FLEXPEN	3
APIDRA INJ SOLOSTAR	1
HUMALOG INJ 100/ML	1
HUMALOG KWIK INJ 100/ML	1
Grand Total	**5274**

Top 10 Drug Group by Paid Amt

Q4 2014

Class	Drug Class Name	Count of Claims	Pharmacy Paid
12	ANTIVIRALS*	4,468	$ 8,504,634.14
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	27,128	$ 7,683,927.56
85	HEMATOLOGICAL AGENTS - MISC.*	3,372	$ 6,979,163.17
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	37,789	$ 3,711,803.05
27	ANTIDIABETICS*	23,521	$ 3,238,990.79
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	3,514	$ 2,928,075.06
72	ANTICONVULSANTS*	38,048	$ 2,690,144.60
65	ANALGESICS - OPIOID*	61,598	$ 2,362,958.40
61	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREX	10,496	$ 2,204,887.73
30	ENDOCRINE AND METABOLIC AGENTS - MISC.*	3,724	$ 2,014,499.56

Q1 2015

Class	Drug Class Name	Count of Claims	Pharmacy Paid
12	ANTIVIRALS*	6,331	$ 9,423,368.52
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	29,118	$ 8,469,326.81
85	HEMATOLOGICAL AGENTS - MISC.*	3,760	$ 7,597,768.53
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	45,060	$ 4,232,146.44
27	ANTIDIABETICS*	26,958	$ 3,630,467.57
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	3,892	$ 3,205,358.07
72	ANTICONVULSANTS*	41,585	$ 2,921,342.97
65	ANALGESICS - OPIOID*	64,322	$ 2,402,423.76
61	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREX	10,790	$ 2,200,152.41
30	ENDOCRINE AND METABOLIC AGENTS - MISC.*	4,020	$ 1,950,591.19

Q2 2015

Class	Drug Class Name	Count of Claims	Pharmacy Paid
12	ANTIVIRALS*	4,622	$ 9,293,084.82
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	28,777	$ 8,506,258.10
85	HEMATOLOGICAL AGENTS - MISC.*	3,703	$ 6,030,795.54
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	41,442	$ 4,226,996.10
27	ANTIDIABETICS*	26,923	$ 3,802,100.22
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	3,926	$ 3,439,852.03
72	ANTICONVULSANTS*	42,089	$ 3,099,553.62
65	ANALGESICS - OPIOID*	64,452	$ 2,393,837.03
61	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREX	10,648	$ 2,198,471.14
30	ENDOCRINE AND METABOLIC AGENTS - MISC.*	3,967	$ 2,097,093.92

Top 10 Drug Group by Claim Count

Q4 2014

Class	Drug Class Name	Count of Claims	Pharmacy Paid
65	ANALGESICS - OPIOID*	61,598	$ 2,362,958.40
72	ANTICONVULSANTS*	38,048	$ 2,690,144.60
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	37,789	$ 3,711,803.05
58	ANTIDEPRESSANTS*	36,919	$ 837,021.47
36	ANTIHYPERTENSIVES*	31,101	$ 349,762.95
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	27,128	$ 7,683,927.56
57	ANTIANXIETY AGENTS*	23,977	$ 200,978.33
39	ANTIHYPERLIPIDEMICS*	23,655	$ 804,254.01
27	ANTIDIABETICS*	23,521	$ 3,238,990.79
49	ULCER DRUGS*	21,208	$ 1,079,722.12

Q1 2015

Class	Drug Class Name	Count of Claims	Pharmacy Paid
65	ANALGESICS - OPIOID*	64,322	$ 2,402,423.76
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	45,060	$ 4,232,146.44
72	ANTICONVULSANTS*	41,585	$ 2,921,342.97
58	ANTIDEPRESSANTS*	40,769	$ 891,896.61
36	ANTIHYPERTENSIVES*	34,257	$ 328,370.97
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	29,118	$ 8,469,326.81
27	ANTIDIABETICS*	26,958	$ 3,630,467.57
39	ANTIHYPERLIPIDEMICS*	26,492	$ 872,061.42
57	ANTIANXIETY AGENTS*	25,408	$ 212,408.32
49	ULCER DRUGS*	23,697	$ 1,121,417.92

Q2 2015

Class	Drug Class Name	Count of Claims	Pharmacy Paid
65	ANALGESICS - OPIOID*	64,452	$ 2,393,837.03
72	ANTICONVULSANTS*	42,089	$ 3,099,553.62
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	41,442	$ 4,226,996.10
58	ANTIDEPRESSANTS*	41,422	$ 970,548.06
36	ANTIHYPERTENSIVES*	34,499	$ 321,361.53
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	28,777	$ 8,506,258.10
27	ANTIDIABETICS*	26,923	$ 3,802,100.22
39	ANTIHYPERLIPIDEMICS*	26,790	$ 914,895.63
57	ANTIANXIETY AGENTS*	25,477	$ 208,833.54
66	ANALGESICS - ANTI-INFLAMMATORY*	23,452	$ 1,351,389.52

Top 10 Drug Classes by Paid Amt

Q4 2014

Class	Drug Class Name	Count of Claims	Pharmacy Paid
8510	ANTIHEMOPHILIC PRODUCTS**	124	$ 6,483,141.59
1235	HEPATITIS AGENTS**	332	$ 5,947,397.39
5925	QUINOLINONE DERIVATIVES**	4,203	$ 3,636,167.83
2710	INSULIN**	7,686	$ 2,477,258.93
1210	ANTIRETROVIRALS**	2,245	$ 2,371,303.70
4420	SYMPATHOMIMETICS**	25,497	$ 2,148,741.41
7260	ANTICONVULSANTS - MISC.**	26,416	$ 1,761,055.45
5907	BENZISOXAZOLES**	6,765	$ 1,725,772.87
5915	DIBENZAPINES**	10,027	$ 1,250,108.53
6240	MULTIPLE SCLEROSIS AGENTS**	272	$ 1,238,233.66

Q1 2015

Class	Drug Class Name	Count of Claims	Pharmacy Paid
8510	ANTIHEMOPHILIC PRODUCTS**	148	$ 7,200,843.43
1235	HEPATITIS AGENTS**	319	$ 6,292,250.83
5925	QUINOLINONE DERIVATIVES**	4,504	$ 4,068,454.43
1210	ANTIRETROVIRALS**	2,979	$ 2,815,709.14
2710	INSULIN**	8,941	$ 2,747,234.25
4420	SYMPATHOMIMETICS**	30,823	$ 2,494,868.24
7260	ANTICONVULSANTS - MISC.**	29,237	$ 1,944,711.58
5907	BENZISOXAZOLES**	7,222	$ 1,798,689.64
5915	DIBENZAPINES**	10,860	$ 1,391,828.34
6240	MULTIPLE SCLEROSIS AGENTS**	281	$ 1,263,544.24

Q2 2015

Class	Drug Class Name	Count of Claims	Pharmacy Paid
1235	HEPATITIS AGENTS**	307	$ 6,218,357.25
8510	ANTIHEMOPHILIC PRODUCTS**	129	$ 5,618,885.27
5925	QUINOLINONE DERIVATIVES**	4,245	$ 3,996,152.12
1210	ANTIRETROVIRALS**	2,659	$ 2,922,026.33
2710	INSULIN**	8,574	$ 2,752,879.41
4420	SYMPATHOMIMETICS**	27,686	$ 2,479,147.45
7260	ANTICONVULSANTS - MISC.**	29,948	$ 2,097,077.40
5907	BENZISOXAZOLES**	7,009	$ 1,760,173.64
5915	DIBENZAPINES**	11,008	$ 1,424,875.18
6240	MULTIPLE SCLEROSIS AGENTS**	275	$ 1,356,105.36

Top 10 Drug Classes by Claim Count

Q4 2014

Class	Drug Class Name	Count of Claims	Pharmacy Paid
6599	OPIOID COMBINATIONS**	35,453	$ 1,028,967.39
7260	ANTICONVULSANTS - MISC.**	26,416	$ 1,761,055.45
6510	OPIOID AGONISTS**	25,600	$ 1,234,264.94
4420	SYMPATHOMIMETICS**	25,497	$ 2,148,741.41
6610	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*	20,575	$ 397,015.36
3940	HMG COA REDUCTASE INHIBITORS**	19,117	$ 353,605.23
5710	BENZODIAZEPINES**	19,078	$ 135,647.26
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**	18,977	$ 167,907.49
7510	CENTRAL MUSCLE RELAXANTS**	14,722	$ 234,927.34
3610	ACE INHIBITORS**	14,065	$ 92,980.74

Q1 2015

Class	Drug Class Name	Count of Claims	Pharmacy Paid
6599	OPIOID COMBINATIONS**	37,462	$ 1,062,192.77
4420	SYMPATHOMIMETICS**	30,823	$ 2,494,868.24
7260	ANTICONVULSANTS - MISC.**	29,237	$ 1,944,711.58
6510	OPIOID AGONISTS**	26,305	$ 1,234,781.01
6610	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*	23,224	$ 367,697.06
3940	HMG COA REDUCTASE INHIBITORS**	21,172	$ 385,791.59
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**	20,686	$ 183,401.32
5710	BENZODIAZEPINES**	19,974	$ 143,945.18
7510	CENTRAL MUSCLE RELAXANTS**	15,606	$ 243,075.03
3610	ACE INHIBITORS**	15,426	$ 99,931.93

Q2 2015

Class	Drug Class Name	Count of Claims	Pharmacy Paid
6599	OPIOID COMBINATIONS**	37,803	$ 1,061,157.18
7260	ANTICONVULSANTS - MISC.**	29,948	$ 2,097,077.40
4420	SYMPATHOMIMETICS**	27,686	$ 2,479,147.45
6510	OPIOID AGONISTS**	26,006	$ 1,207,181.46
6610	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*	23,057	$ 343,929.54
3940	HMG COA REDUCTASE INHIBITORS**	21,444	$ 402,612.98
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**	21,105	$ 192,784.39
5710	BENZODIAZEPINES**	19,763	$ 136,699.52
7510	CENTRAL MUSCLE RELAXANTS**	15,622	$ 247,718.77
3610	ACE INHIBITORS**	15,598	$ 102,809.91

Top 50 Drugs by Amount - Q4 2014

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
5925001500	ARIPIPRAZOLE	4203	$ 3,636,167.83	21	18
8510001025	ANTIHEMOPHILIC FACTOR RAHF-PFM	26	$ 3,287,092.39	54,794	16
1235990240	LEDIPASVIR-SOFOSBUVIR	102	$ 2,956,433.92	16	16
1235308000	SOFOSBUVIR	99	$ 2,657,888.92	15	15
8510001026	ANTIHEMOPHILIC FACTOR (RECOMBINANT) PLASMA/ALBLUMIN FREE	19	$ 1,124,529.80	13,823	9
2710400300	INSULIN GLARGINE	3133	$ 1,039,653.64	12	25
1950206000	PALIVIZUMAB	407	$ 971,315.39	1	18
8510001000	ANTIHEMOPHILIC FACTOR (HUMAN)	5	$ 909,227.52	152,372	27
5907005010	PALIPERIDONE PALMITATE	586	$ 895,252.39	1	24
4927002510	ESOMEPRAZOLE MAGNESIUM	3847	$ 840,377.85	23	22
4420990270	FLUTICASONE-SALMETEROL	3145	$ 840,005.60	45	23
5915307010	QUETIAPINE FUMARATE	6610	$ 828,408.65	30	20
5940002310	LURASIDONE HCL	1104	$ 814,253.85	15	14
4420101010	ALBUTEROL SULFATE	18082	$ 753,958.27	42	16
9410003000	GLUCOSE BLOOD	5985	$ 727,299.29	70	21
6510007510	OXYCODONE HCL	7825	$ 563,217.49	73	18
6135303010	GUANFACINE HCL (ADHD)	1711	$ 553,254.34	20	17
3030001000	CORTICOTROPIN	17	$ 549,122.44	2	5
4410008010	TIOTROPIUM BROMIDE MONOHYDRATE	2231	$ 508,666.85	26	26
8240157000	PEGFILGRASTIM	109	$ 506,187.12	1	3
8510001510	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	50	$ 504,302.54	5,235	9
6599170210	HYDROCODONE-ACETAMINOPHEN	22615	$ 491,601.83	55	13
6599000220	OXYCODONE W/ ACETAMINOPHEN	10297	$ 483,437.76	51	12
7260005700	PREGABALIN	1916	$ 473,314.13	50	21
1210990230	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	388	$ 469,187.54	20	20
2710400500	INSULIN LISPRO (HUMAN)	1241	$ 446,756.00	11	20
6240552500	DIMETHYL FUMARATE	87	$ 446,305.76	22	11
6110990210	AMPHETAMINE-DEXTROAMPHETAMINE	2869	$ 446,230.71	26	18
8510001020	ANTIHEMOPHILIC FACTOR (RECOMBINANT)	12	$ 417,607.27	9,138	8
5907005000	PALIPERIDONE	390	$ 409,331.27	21	16
7250001010	DIVALPROEX SODIUM	4267	$ 392,241.84	53	18
2710400200	INSULIN ASPART	1246	$ 382,606.01	11	20
6629003000	ETANERCEPT	139	$ 369,088.32	2	14
3010002000	SOMATROPIN	137	$ 367,750.01	2	11
4420990241	BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE	1994	$ 359,869.68	8	24
8580005000	ECULIZUMAB	18	$ 348,665.58	95	1
3090685000	IDURSULFASE	17	$ 345,488.54	19	9
2135307000	TRASTUZUMAB	80	$ 344,697.38	1	2
0700007000	TOBRAMYCIN	72	$ 334,530.59	131	14
5818002510	DULOXETINE HCL	1893	$ 332,664.60	23	18
6110002510	LISDEXAMFETAMINE DIMESYLATE	1677	$ 326,933.74	23	23
1210990430	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR	135	$ 312,348.17	19	19
6140002010	METHYLPHENIDATE HCL	2225	$ 310,302.21	34	18
1210990330	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	152	$ 308,339.02	19	18
6627001500	ADALIMUMAB	111	$ 300,211.89	1	15
1910002010	IMMUNE GLOBULIN (HUMAN) IV	94	$ 285,168.97	314	4
7260003600	LACOSAMIDE	599	$ 277,355.61	54	14
4530402000	DORNASE ALFA	108	$ 270,423.92	48	17
2710400600	INSULIN DETEMIR	862	$ 269,279.85	9	17
6510005510	MORPHINE SULFATE	6052	$ 256,449.38	30	12

Top 50 Drugs by Amount - Q1 2015

Drug Code	Drug Name	Claim Count		Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
8510001025	ANTIHEMOPHILIC FACTOR RAHF-PFM	35	$	5,070,707.93	49,113	12
1235990240	LEDIPASVIR-SOFOSBUVIR	164	$	4,628,500.60	17	17
5925001500	ARIPIPRAZOLE	4,504	$	4,068,454.43	21	18
1235308000	SOFOSBUVIR	57	$	1,571,069.00	14	14
1950206000	PALIVIZUMAB	499	$	1,228,964.43	1	21
2710400300	INSULIN GLARGINE	3,611	$	1,131,548.33	13	27
8510001000	ANTIHEMOPHILIC FACTOR (HUMAN)	6	$	1,066,124.91	141,625	30
5907005010	PALIPERIDONE PALMITATE	703	$	946,879.96	1	23
5940002310	LURASIDONE HCL	1,289	$	945,176.26	18	16
5915307010	QUETIAPINE FUMARATE	7,106	$	934,912.48	30	20
4420990270	FLUTICASONE-SALMETEROL	3,461	$	907,251.13	44	23
4420101010	ALBUTEROL SULFATE	21,840	$	897,575.07	43	15
4927002510	ESOMEPRAZOLE MAGNESIUM	4,254	$	878,644.88	21	20
9410003000	GLUCOSE BLOOD	6,073	$	753,955.47	70	21
6510007510	OXYCODONE HCL	8,330	$	580,171.58	74	18
6135303010	GUANFACINE HCL (ADHD)	1,734	$	552,627.44	18	16
1210990230	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	506	$	535,677.10	21	21
7260005700	PREGABALIN	2,244	$	533,299.56	51	22
4410008010	TIOTROPIUM BROMIDE MONOHYDRATE	2,592	$	524,100.25	25	25
6599000220	OXYCODONE W/ ACETAMINOPHEN	11,010	$	509,284.25	51	12
6599170210	HYDROCODONE-ACETAMINOPHEN	23,867	$	499,286.73	60	15
2710400500	INSULIN LISPRO (HUMAN)	1,364	$	496,350.07	12	23
3030001000	CORTICOTROPIN	11	$	493,630.36	4	5
8240157000	PEGFILGRASTIM	104	$	492,118.64	1	2
8510001510	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	66	$	475,994.83	3,476	6
3010002000	SOMATROPIN	152	$	431,678.45	2	12
4420990241	BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE	2,504	$	423,583.58	8	25
5907005000	PALIPERIDONE	450	$	423,006.22	21	17
6240552500	DIMETHYL FUMARATE	80	$	411,171.52	20	10
2710400200	INSULIN ASPART	1,472	$	405,772.90	12	22
7250001010	DIVALPROEX SODIUM	4,610	$	379,850.90	55	19
1210990430	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR	194	$	379,486.99	19	19
6110002510	LISDEXAMFETAMINE DIMESYLATE	1,761	$	370,631.07	22	22
6629003000	ETANERCEPT	139	$	367,741.77	2	15
1210990330	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	220	$	364,062.21	21	21
6110990210	AMPHETAMINE-DEXTROAMPHETAMINE	3,017	$	352,212.72	25	18
0700007000	TOBRAMYCIN	68	$	348,498.68	164	17
5818002510	DULOXETINE HCL	2,056	$	336,790.63	24	18
6627001500	ADALIMUMAB	140	$	334,722.32	1	14
6140002010	METHYLPHENIDATE HCL	2,263	$	327,243.31	32	17
2710400600	INSULIN DETEMIR	1,068	$	326,388.92	11	21
1910002010	IMMUNE GLOBULIN (HUMAN) IV	134	$	325,021.07	275	3
9085006000	LIDOCAINE	983	$	319,433.38	50	15
7260003600	LACOSAMIDE	656	$	307,897.17	50	16
2153253000	EVEROLIMUS	25	$	299,755.22	10	9
4440001500	BUDESONIDE (INHALATION)	942	$	297,759.39	50	17
2135307000	TRASTUZUMAB	66	$	290,096.83	1	2
4530402000	DORNASE ALFA	100	$	282,768.18	42	15
6135401510	ATOMOXETINE HCL	890	$	278,500.98	18	16
8580005000	ECULIZUMAB	14	$	271,238.40	94	1

Top 50 Drugs by Amount - Q2 2015

Drug Code	Drug Name	Claim Count		Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
1235990240	LEDIPASVIR-SOFOSBUVIR	166	$	4,579,092.77	14	14
5925001500	ARIPIPRAZOLE	4,245	$	3,996,152.12	16	14
8510001025	ANTIHEMOPHILIC FACTOR RAHF-PFM	21	$	2,961,926.91	52,962	12
1235308000	SOFOSBUVIR	53	$	1,456,811.12	11	11
2710400300	INSULIN GLARGINE	3,545	$	1,130,416.75	12	26
5940002310	LURASIDONE HCL	1,355	$	1,049,023.38	16	15
5915307010	QUETIAPINE FUMARATE	7,217	$	969,519.88	30	20
8510001000	ANTIHEMOPHILIC FACTOR (HUMAN)	6	$	937,026.57	124,475	25
5907005010	PALIPERIDONE PALMITATE	655	$	932,526.98	1	23
4420990270	FLUTICASONE-SALMETEROL	3,319	$	899,385.51	43	23
4927002510	ESOMEPRAZOLE MAGNESIUM	4,181	$	888,266.05	21	21
4420101010	ALBUTEROL SULFATE	19,078	$	829,951.53	40	16
9410003000	GLUCOSE BLOOD	6,421	$	804,795.06	72	22
8510001020	ANTIHEMOPHILIC FACTOR (RECOMBINANT)	10	$	605,431.66	14,979	11
7260005700	PREGABALIN	2,287	$	589,071.16	52	22
1210990230	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	457	$	581,649.44	23	23
4410008010	TIOTROPIUM BROMIDE MONOHYDRATE	2,598	$	581,441.47	25	25
3030001000	CORTICOTROPIN	14	$	568,502.44	3	3
6135303010	GUANFACINE HCL (ADHD)	1,802	$	568,020.97	19	17
6510007510	OXYCODONE HCL	8,262	$	541,829.26	74	18
8510001510	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	52	$	523,873.08	5,644	8
2710400500	INSULIN LISPRO (HUMAN)	1,323	$	510,875.85	11	22
6599000220	OXYCODONE W/ ACETAMINOPHEN	11,179	$	509,169.70	55	14
6599170210	HYDROCODONE-ACETAMINOPHEN	24,198	$	499,069.26	61	15
3010002000	SOMATROPIN	154	$	476,573.09	2	10
6240552500	DIMETHYL FUMARATE	87	$	473,786.60	21	10
4420990241	BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE	2,529	$	466,089.66	8	25
6629003000	ETANERCEPT	151	$	451,225.70	2	15
2710400200	INSULIN ASPART	1,325	$	420,334.15	11	21
5907005000	PALIPERIDONE	395	$	410,798.52	23	18
1210990430	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR	173	$	403,181.31	20	20
8240157000	PEGFILGRASTIM	85	$	388,411.32	1	2
9085006000	LIDOCAINE	983	$	388,356.64	54	16
2153253000	EVEROLIMUS	33	$	386,232.32	19	16
6110002510	LISDEXAMFETAMINE DIMESYLATE	1,775	$	378,542.92	23	22
5818002510	DULOXETINE HCL	2,024	$	377,279.16	22	17
1210990330	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	185	$	375,439.13	20	20
6627001500	ADALIMUMAB	110	$	374,869.62	1	12
6140002010	METHYLPHENIDATE HCL	2,299	$	356,765.71	33	18
0700007000	TOBRAMYCIN	73	$	345,648.54	125	13
7250001010	DIVALPROEX SODIUM	4,565	$	341,684.49	56	19
6110990210	AMPHETAMINE-DEXTROAMPHETAMINE	2,885	$	334,130.37	28	20
7260003600	LACOSAMIDE	653	$	330,027.36	56	16
2710400600	INSULIN DETEMIR	1,014	$	327,051.03	11	21
1910002010	IMMUNE GLOBULIN (HUMAN) IV	113	$	323,519.39	354	3
4530402000	DORNASE ALFA	106	$	302,773.80	48	17
9310002500	DEFERASIROX	50	$	296,073.94	31	12
8580005000	ECULIZUMAB	15	$	292,961.34	94	1
6135401510	ATOMOXETINE HCL	839	$	279,292.47	19	17
4460306000	OMALIZUMAB	97	$	275,234.06	2	16

Top 50 Drugs by Claim Count - Q4 2014

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
6599170210	HYDROCODONE-ACETAMINOPHEN	22615	$ 491,601.83	55	13
4420101010	ALBUTEROL SULFATE	18082	$ 753,958.27	42	16
3610003000	LISINOPRIL	12423	$ 68,245.04	31	28
7260003000	GABAPENTIN	10661	$ 195,663.17	69	22
5710001000	ALPRAZOLAM	10565	$ 88,571.88	52	22
6599000220	OXYCODONE W/ ACETAMINOPHEN	10297	$ 483,437.76	51	12
6610002000	IBUPROFEN	9771	$ 60,767.95	47	13
2810001010	LEVOTHYROXINE SODIUM	9161	$ 98,696.16	28	28
3400000310	AMLODIPINE BESYLATE	8845	$ 43,406.79	27	26
2725005000	METFORMIN HCL	8707	$ 68,667.87	54	26
6510007510	OXYCODONE HCL	7825	$ 563,217.49	73	18
0120001010	AMOXICILLIN	7580	$ 63,406.59	63	6
3940007500	SIMVASTATIN	6960	$ 41,083.13	28	28
5915307010	QUETIAPINE FUMARATE	6610	$ 828,408.65	30	20
3940001010	ATORVASTATIN CALCIUM	6552	$ 77,301.22	26	26
5812008010	TRAZODONE HCL	6490	$ 50,704.17	32	24
5025006505	ONDANSETRON HCL	6235	$ 36,144.18	4	2
6510009510	TRAMADOL HCL	6213	$ 52,385.26	60	15
0340001000	AZITHROMYCIN	6125	$ 82,705.38	8	4
6510005510	MORPHINE SULFATE	6052	$ 256,449.38	30	12
9410003000	GLUCOSE BLOOD	5985	$ 727,299.29	70	21
5816007010	SERTRALINE HCL	5928	$ 48,325.71	27	22
3320003010	METOPROLOL TARTRATE	5831	$ 28,162.87	39	21
4450505010	MONTELUKAST SODIUM	5810	$ 141,311.22	21	21
6020408010	ZOLPIDEM TARTRATE	5619	$ 41,533.66	24	24
5907007000	RISPERIDONE	5413	$ 129,270.64	34	20
4920002010	RANITIDINE HCL	5352	$ 49,978.57	47	23
4220003230	FLUTICASONE PROPIONATE (NASAL)	5174	$ 117,045.11	12	23
6410001000	ASPIRIN	5128	$ 19,171.16	21	21
5816002010	CITALOPRAM HYDROBROMIDE	5056	$ 28,941.53	25	24
7510005010	CYCLOBENZAPRINE HCL	5030	$ 41,770.39	44	20
7210001000	CLONAZEPAM	4995	$ 29,860.87	46	22
3720003000	FUROSEMIDE	4769	$ 20,189.38	28	22
5816004000	FLUOXETINE HCL	4610	$ 51,135.58	29	22
3620101010	CLONIDINE HCL	4493	$ 54,750.27	38	21
4155003000	LORATADINE	4468	$ 30,270.52	33	21
5710006000	LORAZEPAM	4422	$ 25,378.35	24	11
2210004500	PREDNISONE	4417	$ 22,078.42	16	8
7250001010	DIVALPROEX SODIUM	4267	$ 392,241.84	53	18
5925001500	ARIPIPRAZOLE	4203	$ 3,636,167.83	21	18
5710004000	DIAZEPAM	3886	$ 19,821.21	43	19
4927002510	ESOMEPRAZOLE MAGNESIUM	3847	$ 840,377.85	23	22
3760004000	HYDROCHLOROTHIAZIDE	3809	$ 18,404.43	27	27
3615004020	LOSARTAN POTASSIUM	3589	$ 22,712.87	31	30
3330000700	CARVEDILOL	3549	$ 23,253.15	48	24
5025006500	ONDANSETRON	3443	$ 55,252.51	9	3
7720203200	CHOLECALCIFEROL	3428	$ 18,152.96	26	22
4920003000	FAMOTIDINE	3338	$ 26,771.27	31	19
7260004000	LAMOTRIGINE	3302	$ 189,153.92	45	21
7260004300	LEVETIRACETAM	3279	$ 175,214.12	110	17

Top 50 Drugs by Claim Count - Q1 2015

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
6599170210	HYDROCODONE-ACETAMINOPHEN	23867	$ 499,286.73	60	15
4420101010	ALBUTEROL SULFATE	21840	$ 897,575.07	43	15
3610003000	LISINOPRIL	13663	$ 71,880.44	32	29
7260003000	GABAPENTIN	11955	$ 214,697.54	71	22
6610002000	IBUPROFEN	11351	$ 69,969.31	46	12
5710001000	ALPRAZOLAM	11162	$ 89,248.90	52	22
6599000220	OXYCODONE W/ ACETAMINOPHEN	11010	$ 509,284.25	51	12
3400000310	AMLODIPINE BESYLATE	9962	$ 47,406.56	29	28
2810001010	LEVOTHYROXINE SODIUM	9699	$ 105,128.36	29	29
2725005000	METFORMIN HCL	9639	$ 73,305.31	56	27
0120001010	AMOXICILLIN	8976	$ 77,080.15	65	7
6510007510	OXYCODONE HCL	8330	$ 580,171.58	74	18
3940001010	ATORVASTATIN CALCIUM	7713	$ 87,896.77	26	26
0340001000	AZITHROMYCIN	7619	$ 102,920.68	8	4
3940007500	SIMVASTATIN	7278	$ 41,525.67	29	29
5812008010	TRAZODONE HCL	7174	$ 49,983.28	32	24
5915307010	QUETIAPINE FUMARATE	7106	$ 934,912.48	30	20
5025006505	ONDANSETRON HCL	7090	$ 41,581.42	5	2
4220003230	FLUTICASONE PROPIONATE (NASAL)	7060	$ 155,020.86	13	24
4450505010	MONTELUKAST SODIUM	6607	$ 155,814.61	23	23
3320003010	METOPROLOL TARTRATE	6296	$ 29,547.13	40	22
5816007010	SERTRALINE HCL	6296	$ 49,933.02	29	23
6510009510	TRAMADOL HCL	6099	$ 49,760.28	61	16
9410003000	GLUCOSE BLOOD	6073	$ 753,955.47	70	21
6510005510	MORPHINE SULFATE	6058	$ 248,977.76	32	13
6020408010	ZOLPIDEM TARTRATE	5925	$ 41,199.05	23	23
5907007000	RISPERIDONE	5640	$ 134,473.45	36	21
2210004500	PREDNISONE	5624	$ 27,020.44	16	9
4920002010	RANITIDINE HCL	5545	$ 51,493.10	46	23
7510005010	CYCLOBENZAPRINE HCL	5422	$ 44,266.66	47	21
7210001000	CLONAZEPAM	5358	$ 31,127.25	46	22
3720003000	FUROSEMIDE	5354	$ 22,112.76	31	24
6410001000	ASPIRIN	5336	$ 19,574.06	22	21
5816002010	CITALOPRAM HYDROBROMIDE	5228	$ 29,302.33	26	25
4155003000	LORATADINE	5066	$ 35,543.82	37	22
5816004000	FLUOXETINE HCL	4945	$ 53,976.65	29	23
3620101010	CLONIDINE HCL	4781	$ 61,969.18	37	21
7250001010	DIVALPROEX SODIUM	4610	$ 379,850.90	55	19
5710006000	LORAZEPAM	4520	$ 32,768.58	25	11
5925001500	ARIPIPRAZOLE	4504	$ 4,068,454.43	21	18
0199000220	AMOXICILLIN & POT CLAVULANATE	4269	$ 119,878.38	39	7
4927002510	ESOMEPRAZOLE MAGNESIUM	4254	$ 878,644.88	21	20
3615004020	LOSARTAN POTASSIUM	4162	$ 26,492.14	27	25
5025006500	ONDANSETRON	4098	$ 64,312.42	9	3
3330000700	CARVEDILOL	4081	$ 24,533.54	49	24
5710004000	DIAZEPAM	4081	$ 20,328.21	43	19
3760004000	HYDROCHLOROTHIAZIDE	4073	$ 19,547.77	27	27
4927007010	PANTOPRAZOLE SODIUM	3918	$ 31,584.80	18	17
7720203200	CHOLECALCIFEROL	3797	$ 20,273.84	27	22
4927006000	OMEPRAZOLE	3690	$ 11,146.10	34	30

Top 50 Drugs by Claim Count - Q2 2015

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
6599170210	HYDROCODONE-ACETAMINOPHEN	24198	$ 499,069.26	61	15
4420101010	ALBUTEROL SULFATE	19078	$ 829,951.53	40	16
3610003000	LISINOPRIL	13847	$ 72,995.08	32	29
7260003000	GABAPENTIN	12260	$ 218,820.40	71	23
6599000220	OXYCODONE W/ ACETAMINOPHEN	11179	$ 509,169.70	55	14
5710001000	ALPRAZOLAM	11003	$ 85,929.11	53	22
6610002000	IBUPROFEN	10947	$ 67,420.24	40	12
3400000310	AMLODIPINE BESYLATE	10123	$ 48,303.28	29	27
2810001010	LEVOTHYROXINE SODIUM	9879	$ 109,218.99	29	29
2725005000	METFORMIN HCL	9863	$ 83,869.73	53	26
3940001010	ATORVASTATIN CALCIUM	8307	$ 95,577.92	23	23
6510007510	OXYCODONE HCL	8262	$ 541,829.26	74	18
5812008010	TRAZODONE HCL	7357	$ 47,819.54	32	24
0120001010	AMOXICILLIN	7259	$ 59,230.54	58	7
5915307010	QUETIAPINE FUMARATE	7217	$ 969,519.88	30	20
4220003230	FLUTICASONE PROPIONATE (NASAL)	7119	$ 155,805.88	12	22
3940007500	SIMVASTATIN	7114	$ 40,275.27	29	29
5025006505	ONDANSETRON HCL	6781	$ 37,636.99	5	2
4450505010	MONTELUKAST SODIUM	6652	$ 160,671.20	23	22
5816007010	SERTRALINE HCL	6523	$ 51,280.34	28	23
9410003000	GLUCOSE BLOOD	6421	$ 804,795.06	72	22
3320003010	METOPROLOL TARTRATE	6350	$ 30,138.99	41	22
6510009510	TRAMADOL HCL	6101	$ 47,351.90	58	15
6510005510	MORPHINE SULFATE	6041	$ 244,359.31	33	14
6020408010	ZOLPIDEM TARTRATE	5605	$ 40,756.71	25	25
5907007000	RISPERIDONE	5580	$ 127,881.12	36	21
7510005010	CYCLOBENZAPRINE HCL	5520	$ 45,364.75	46	20
3720003000	FUROSEMIDE	5490	$ 23,116.92	31	24
4155003000	LORATADINE	5423	$ 37,904.24	37	22
6410001000	ASPIRIN	5343	$ 19,933.83	23	23
7210001000	CLONAZEPAM	5265	$ 31,058.54	47	23
4920002010	RANITIDINE HCL	5261	$ 48,319.67	46	23
0340001000	AZITHROMYCIN	5203	$ 69,128.29	8	4
5816002010	CITALOPRAM HYDROBROMIDE	5201	$ 29,247.05	26	24
5816004000	FLUOXETINE HCL	5009	$ 60,950.56	30	23
2210004500	PREDNISONE	4904	$ 23,964.20	17	9
3620101010	CLONIDINE HCL	4593	$ 56,004.12	36	21
7250001010	DIVALPROEX SODIUM	4565	$ 341,684.49	56	19
5710006000	LORAZEPAM	4520	$ 28,757.49	24	11
7720203200	CHOLECALCIFEROL	4265	$ 22,433.46	25	21
3615004020	LOSARTAN POTASSIUM	4256	$ 27,805.14	28	26
5925001500	ARIPIPRAZOLE	4245	$ 3,996,152.12	16	14
4927002510	ESOMEPRAZOLE MAGNESIUM	4181	$ 888,266.05	21	21
3330000700	CARVEDILOL	4097	$ 23,972.38	51	25
5710004000	DIAZEPAM	4009	$ 20,245.80	41	18
3760004000	HYDROCHLOROTHIAZIDE	4004	$ 19,579.19	28	27
5025006500	ONDANSETRON	4000	$ 61,678.41	10	4
4927007010	PANTOPRAZOLE SODIUM	3984	$ 34,255.73	18	17
4155002010	CETIRIZINE HCL	3875	$ 28,774.98	37	19
7260004000	LAMOTRIGINE	3828	$ 254,136.81	44	21

No Patient Health Information

RXT6050D - Summarized DUR Activity Report

Between Oct 1, 2014 and Dec 31, 2014

Jan 13, 2015
3:14:33 PM

Claims Summary:

RxCLAIM Status	Total Rxs	% of Total Rxs	Total Plan Paid	Total Member Paid
Paid	669,114	64.9%	$62,158,754.84	$0.00
Rejected	283,325	27.5%	$40,969,480.24	$0.00
Reversed	78,736	7.6%	-$13,791,232.46	$0.00
Totals	1,031,175	100%	$89,337,002.62	$0.00

DUR Information Summary:

		Total DURs		DURs on Paid Rxs		DURs on Rejected Rxs		DURs on Reversed Rxs	
DUR Type	Clinical Level	Count	% of All DURs	Count	% of DUR Type	Count	% of DUR Type	Count	% of DUR Type
LR - Underuse Precaution	0 - NS	56,821	22.8%	51,327	90.3%	0	0.0%	5,494	9.7%
TD - Therapeutic Duplication	0 - NS	56,687	22.7%	42,122	74.3%	7,414	13.1%	7,151	12.6%
ID - Ingredient Duplication	2 - Mod	45,384	18.2%	11,688	25.8%	30,589	67.4%	3,107	6.8%
DD - Drug-Drug Interaction	1 - Maj	35,093	14.1%	28,606	81.5%	3,487	9.9%	3,000	8.5%
LD - Low Dose Alert	0 - NS	23,888	9.6%	20,293	85.0%	0	0.0%	3,595	15.0%
HD - High Dose Alert	0 - NS	18,352	7.4%	16,142	88.0%	180	1.0%	2,030	11.1%
MN - Insufficnt Duration Alert	0 - NS	8,863	3.6%	6,291	71.0%	0	0.0%	2,572	29.0%
MX - Excessive Duration Alert	0 - NS	4,242	1.7%	3,872	91.3%	0	0.0%	370	8.7%
PA - Drug-Age Precaution	1 - Maj	44	0.0%	38	86.4%	0	0.0%	6	13.6%
Total All DURs		249,374	100.0%	180,379	72.3%	41,670	16.7%	27,325	11.0%

* DUR Information Summary results are sorted by Total DUR count in descending order
* Some Rx claims could have multiple DUR messages. And there could be multiple instances of the same DUR message on a Rx claim
* The Count and % of DUR Type for Paid, Rejected and Reversed Rxs are based on DUR Type totals for each row

DD - Drug-Drug Interaction

Rank	Top Drug Drug Interaction	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	CARISOPRODOL - ALPRAZOLAM	Message Only	840	$6,502.86	$7.74	$0.00	28.0	76.7	126	38	$290.04
2	OXYCODONE HCL - CARISOPRODOL	Message Only	416	$20,277.30	$48.74	$0.00	27.8	116.5	36	14	$632.71
3	OXYCODONE - CARISOPRODOL	Message Only	384	$3,785.02	$9.86	$0.00	29.2	83.1	56	16	$113.24
4	SIMVASTATIN - FENOFIBRATE	Message Only	341	$13,612.82	$39.92	$0.00	33.6	33.8	69	25	$825.85
5	TRAZODONE HCL - CITALOPRAM	Message Only	368	$3,581.28	$9.73	$0.00	30.1	38.0	35	19	$409.20
6	OXYCODONE/ACETAMINOPHEN - CARISOPRODOL	Message Only	343	$22,217.59	$64.77	$0.00	26.5	109.1	45	25	$2,024.38
7	OXYCOD/APAP - CARISOPRODOL	Message Only	312	$2,273.16	$7.29	$0.00	28.4	77.6	53	20	$133.71
8	TRAZODONE HCL - QUETIAPINE	Message Only	329	$2,274.11	$6.91	$0.00	27.0	38.8	34	11	$39.15
9	TRAZODONE - CITALOPRAM HYDROBROMIDE	Message Only	317	$1,817.02	$5.73	$0.00	29.7	31.8	38	17	$94.21
10	SPIRONOLACT - LISINOPRIL	Message Only	287	$1,532.79	$5.34	$0.00	37.0	41.6	40	19	$68.53
All Others			24,669	$2,075,769.24	$84.14	$0.00	25.5	48.5	2,955	2,796	$259,493.91
DD - Drug-Drug Interaction			28,606	$2,153,643.19	$75.29	$0.00	26.0	51.2	3,487	3,000	$264,124.93

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

HD - High Dose Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	HYDROCODONE/ ACETAMINOPHEN	ADULT MAX DLY = 6.00 UN	Message Only	569	$18,788.06	$33.02	$0.00	14.5	114.9	0	33	$1,566.09
2	ZOLPIDEM TARTRATE	GERIATRIC MAX DLY = .50UN	Message Only	342	$1,080.45	$3.16	$0.00	29.9	29.9	0	16	$42.00
3	KETOROLAC TROMETHAMINE	GERIATRIC MAX DLY = 2.00UN	Message Only	299	$1,376.39	$4.60	$0.00	1.0	4.3	0	48	$205.77
4	POLYETHYLENE GLYCOL 3350	ADULT MAX DLY = 17.00 UN	Message Only	246	$6,513.82	$26.48	$0.00	28.1	555.3	0	25	$609.58
5	POLYETHYLENE GLYCOL 3350	PEDIATRIC MAX DLY = 17.00UN	Message Only	166	$4,752.82	$28.63	$0.00	28.4	545.6	0	24	$711.73
6	INVEGA SUSTENNA	ADULT MAX DLY = .05 UN	Message Only	181	$339,231.09	$1,874.20	$0.00	26.6	1.5	0	6	$11,520.48
7	MIDAZOLAM HCL	GERIATRIC MAX DLY = .70UN	Message Only	179	$922.92	$5.16	$0.00	1.0	5.7	0	2	$1.80
8	CELESTONE-SOLUSPAN	GERIATRIC MAX DLY = 1.50UN	Message Only	168	$4,704.38	$28.00	$0.00	1.0	4.0	0	2	$91.41
9	ONDANSETRON ODT	ADULT MAX DLY = 3.00 UN	Message Only	140	$3,472.78	$24.81	$0.00	6.7	26.4	0	26	$684.61
10	IBUPROFEN	ADULT MAX DLY = 4.00 UN	Message Only	159	$964.99	$6.07	$0.00	7.5	35.6	0	3	$19.34
All Others				13,693	$2,862,054.62	$209.02	$0.00	13.8	122.2	180	1,845	$466,409.78
HD - High Dose Alert				16,142	$3,243,862.32	$200.96	$0.00	14.0	123.2	180	2,030	$481,862.59

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

ID - Ingredient Duplication

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	HYDROCODONE/ ACETAMINOPHEN	HYDROCO/APAP TAB 10-325MG	Hard Reject	5	$191.13	$38.23	$0.00	17.8	108.0	1,161	0	$0.00
2	OXYCODONE/ ACETAMINOPHEN	OXYCOD/APAP TAB 10-325MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	497	0	$0.00
3	ZOLPIDEM TARTRATE	ZOLPIDEM TAB 10MG	Hard Reject	2	$11.56	$5.78	$0.00	30.0	30.0	468	0	$0.00
4	ALPRAZOLAM	ALPRAZOLAM TAB 1MG	Hard Reject	1	$6.22	$6.22	$0.00	8.0	30.0	425	0	$0.00
5	SODIUM CHLORIDE	SOD CHLORIDE INJ 0.9%	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	425	0	$0.00
6	TRAMADOL HCL	TRAMADOL HCL TAB 50MG	Hard Reject	1	$7.87	$7.87	$0.00	7.0	56.0	409	0	$0.00
7	ALPRAZOLAM	ALPRAZOLAM TAB 2MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	389	0	$0.00
8	PROAIR HFA	PROAIR HFA AER	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	336	0	$0.00
9	GABAPENTIN	GABAPENTIN CAP 300MG	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	326	0	$0.00
10	CLONAZEPAM	CLONAZEPAM TAB 1MG	Hard Reject	2	$12.14	$6.07	$0.00	22.5	45.0	312	0	$0.00
All Others				11,677	$3,171,850.00	$271.63	$0.00	27.3	184.9	25,841	3,107	$401,953.35
ID - Ingredient Duplication				11,688	$3,172,078.92	$271.40	$0.00	27.3	184.8	30,589	3,107	$401,953.35

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

LD - Low Dose Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	ONDANSETRON HCL	GERIATRIC MIN DLY = 2.00UN	Message Only	687	$316.15	$0.46	$0.00	1.9	1.8	0	413	$119.25
2	ONDANSETRON ODT	GERIATRIC MIN DLY = 2.00UN	Message Only	526	$331.40	$0.63	$0.00	1.3	1.1	0	150	$99.46
3	METFORMIN HCL	ADULT MIN DLY = 1.70 UN	Message Only	450	$2,332.30	$5.18	$0.00	35.2	34.9	0	28	$147.25
4	VITAMIN D	ADULT MIN DLY = .14 UN	Message Only	379	$2,331.73	$6.15	$0.00	30.9	2.7	0	35	$222.44
5	GABAPENTIN	ADULT MIN DLY = 3.00 UN	Message Only	371	$2,629.55	$7.09	$0.00	30.1	49.4	0	30	$217.85
6	CITALOPRAM HYDROBROMIDE	ADULT MIN DLY = 2.00 UN	Message Only	360	$2,163.19	$6.01	$0.00	28.7	28.7	0	34	$210.27
7	IPRATROPIUM BROMIDE/ALBUT	GERIATRIC MIN DLY = 12.00UN	Message Only	251	$727.47	$2.90	$0.00	3.4	18.6	0	122	$118.75
8	ZOFRAN ODT	GERIATRIC MIN DLY = 2.00UN	Message Only	253	$5,312.95	$21.00	$0.00	1.0	1.0	0	79	$1,683.49
9	ONDANSETRON HCL	ADULT MIN DLY = 2.00 UN	Message Only	290	$2,292.97	$7.91	$0.00	19.4	12.0	0	26	$204.48
10	PROPRANOLOL HCL	ADULT MIN DLY = 3.00 UN	Message Only	249	$1,402.02	$5.63	$0.00	28.6	52.4	0	17	$97.59
All Others				16,477	$1,953,705.72	$118.57	$0.00	24.4	57.8	0	2,661	$344,409.31
LD - Low Dose Alert				20,293	$1,973,545.45	$97.25	$0.00	23.0	50.3	0	3,595	$347,530.14

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

LR - Underuse Precaution

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	LISINOPRIL	7 DAYS LATE REFILLING	Message Only	83	$417.20	$5.03	$0.00	29.3	32.1	0	5	$26.14
2	LISINOPRIL	8 DAYS LATE REFILLING	Message Only	62	$350.02	$5.65	$0.00	30.6	34.5	0	8	$38.71
3	AMLODIPINE BESYLATE	7 DAYS LATE REFILLING	Message Only	61	$319.22	$5.23	$0.00	29.6	29.4	0	3	$18.83
4	SIMVASTATIN	7 DAYS LATE REFILLING	Message Only	60	$411.82	$6.86	$0.00	30.0	30.2	0	3	$26.06
4	LISINOPRIL	9 DAYS LATE REFILLING	Message Only	59	$298.49	$5.06	$0.00	30.0	32.8	0	4	$19.57
6	LEVOTHYROXINE SODIUM	7 DAYS LATE REFILLING	Message Only	59	$430.53	$7.30	$0.00	30.0	29.2	0	3	$45.62
7	LISINOPRIL	10 DAYS LATE REFILLING	Message Only	48	$251.56	$5.24	$0.00	29.5	31.4	0	3	$17.09
8	PROAIR HFA	11 DAYS LATE REFILLING	Message Only	47	$2,189.89	$46.59	$0.00	21.7	9.2	0	3	$303.09
9	PROAIR HFA	7 DAYS LATE REFILLING	Message Only	48	$2,145.10	$44.69	$0.00	24.2	8.9	0	1	$101.03
9	AMLODIPINE BESYLATE	8 DAYS LATE REFILLING	Message Only	43	$226.41	$5.27	$0.00	30.0	30.7	0	6	$39.38
All Others				50,757	$4,368,294.68	$86.06	$0.00	28.6	51.2	0	5,455	$612,086.93
LR - Underuse Precaution				51,327	$4,375,334.92	$85.24	$0.00	28.6	50.9	0	5,494	$612,722.45

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

MN - Insufficnt Duration Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	IPRATROPIUM BROMIDE/ALBUT	MIN. DAYS THERAPY = 30	Message Only	361	$10,712.14	$29.67	$0.00	9.0	133.8	0	33	$532.98
2	PANTOPRAZOLE SODIUM	MIN. DAYS THERAPY = 7	Message Only	204	$36.38	$0.18	$0.00	1.0	1.1	0	174	$36.16
3		ING01 MIN DAYS THERAPY = 5	Message Only	319	$39,236.46	$123.00	$0.00	1.6	30.3	0	20	$1,882.43
4	LISINOPRIL	MIN. DAYS THERAPY = 7	Message Only	168	$56.20	$0.33	$0.00	1.1	1.4	0	130	$12.56
5	METOPROLOL TARTRATE	MIN. DAYS THERAPY = 7	Message Only	177	$61.98	$0.35	$0.00	1.2	1.9	0	116	$30.41
6	LEVOTHYROXINE SODIUM	MIN. DAYS THERAPY = 10	Message Only	255	$1,095.30	$4.30	$0.00	6.1	6.1	0	23	$26.41
7	LEVETIRACETAM	MIN. DAYS THERAPY = 14	Message Only	258	$2,727.23	$10.57	$0.00	6.8	32.3	0	9	$49.49
8	OLANZAPINE	MIN. DAYS THERAPY = 7	Message Only	141	$143.98	$1.02	$0.00	1.1	1.8	0	112	$96.58
9	SULFAMETHOXAZOLE/ TRIMETHO	MIN. DAYS THERAPY = 5	Message Only	198	$606.85	$3.06	$0.00	1.9	7.1	0	46	$103.41
10	NICOTINE	MIN. DAYS THERAPY = 7	Message Only	130	$252.57	$1.94	$0.00	1.0	1.0	0	99	$193.84
All Others				4,080	$216,057.53	$52.96	$0.00	3.0	21.2	0	1,810	$49,507.07
MN - Insufficnt Duration Alert				6,291	$270,986.62	$43.08	$0.00	3.3	24.9	0	2,572	$52,471.34

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

MX - Excessive Duration Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	CYCLOBENZAPRINE HCL	MAX DAYS THERAPY = 21	Message Only	1,410	$10,860.05	$7.70	$0.00	30.3	65.3	0	96	$771.11
2	AZITHROMYCIN	MAX DAYS THERAPY = 5	Message Only	281	$6,588.74	$23.45	$0.00	11.6	19.2	0	32	$842.14
3	POLYETHYLENE GLYCOL 3350	MAX DAYS THERAPY = 14	Message Only	250	$6,184.26	$24.74	$0.00	26.5	266.6	0	40	$1,093.64
4	FLUCONAZOLE	MAX DAYS THERAPY = 1	Message Only	176	$2,244.10	$12.75	$0.00	3.4	3.5	0	13	$220.55
5	DIPHENOXYLATE/ ATROPINE	MAX DAYS THERAPY = 14	Message Only	147	$2,697.43	$18.35	$0.00	25.6	106.7	0	7	$167.32
6	EPIPEN 2-PAK	MAX DAYS THERAPY = 1	Message Only	129	$47,831.30	$370.79	$0.00	2.2	2.2	0	20	$9,375.33
7	MAPAP	MAX DAYS THERAPY = 10	Message Only	126	$714.27	$5.67	$0.00	26.3	108.8	0	2	$10.98
8	PHENAZOPYRIDINE HCL	MAX DAYS THERAPY = 2	Message Only	107	$1,972.62	$18.44	$0.00	4.4	13.7	0	5	$168.59
9	TRAMADOL HYDROCHLORIDE/AC	MAX DAYS THERAPY = 5	Message Only	96	$2,156.62	$22.46	$0.00	18.7	71.2	0	7	$124.34
10	CEFDINIR	MAX DAYS THERAPY = 10	Message Only	79	$4,349.15	$55.05	$0.00	15.2	73.6	0	2	$171.62
All Others				1,071	$176,568.42	$164.86	$0.00	27.1	77.6	0	146	$69,786.55
MX - Excessive Duration Alert				3,872	$262,166.96	$67.71	$0.00	24.1	75.3	0	370	$82,732.17

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

PA - Drug-Age Precaution

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	PROMETHAZINE-DM	AGE LESS THAN 4	Message Only	13	$92.08	$7.08	$0.00	10.2	101.5	0	0	$0.00
2	PROMETHAZINE/ DEXTROMETHOR	AGE LESS THAN 4	Message Only	10	$62.76	$6.28	$0.00	11.2	98.0	0	2	$16.94
3	PROMETHAZINE/CODEINE	AGE LESS THAN 4	Message Only	6	$40.70	$6.78	$0.00	16.8	108.3	0	1	$7.00
4	PROMETHAZINE HCL	AGE LESS THAN 4	Message Only	4	$35.07	$8.77	$0.00	9.5	70.0	0	2	$14.27
5	PROMETHAZINE HCL PLAIN	AGE LESS THAN 4	Message Only	2	$12.43	$6.22	$0.00	4.0	75.0	0	1	$4.00
6	PROMETHEGAN	AGE LESS THAN 4	Message Only	2	$28.74	$14.37	$0.00	3.5	10.0	0	0	$0.00
7	PROMETHAZINE VC PLAIN	AGE LESS THAN 4	Message Only	1	$16.74	$16.74	$0.00	12.0	90.0	0	0	$0.00
PA - Drug-Age Precaution				38	$288.52	$7.59	$0.00	10.8	91.8	0	6	$42.21

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

TD - Therapeutic Duplication

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	HYDROCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,821	$37,623.27	$20.66	$0.00	17.6	72.2	0	191	$2,475.74
2	OXYCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,243	$50,036.55	$40.25	$0.00	14.7	62.1	0	192	$2,633.25
3	HYDROMORPHONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	810	$5,999.26	$7.41	$0.00	5.9	22.4	0	421	$1,521.96
4	OXYCODONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,120	$55,871.84	$49.89	$0.00	23.3	106.7	0	102	$2,629.58
5	QUETIAPINE FUMARATE	ORAL ANTIPSYCHOTICS	Message Only	1,028	$22,621.49	$22.01	$0.00	27.2	41.5	0	80	$1,064.36
6	MORPHINE SULFATE	SHORT ACTING NARCOTIC ANALGESI	Message Only	709	$4,307.57	$6.08	$0.00	5.9	19.5	0	376	$1,015.45
7	TRAMADOL HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	884	$7,519.90	$8.51	$0.00	19.8	84.4	0	61	$354.80
8	RISPERIDONE	ORAL ANTIPSYCHOTICS	Message Only	750	$11,964.83	$15.95	$0.00	26.7	43.6	0	73	$779.76
9	ALPRAZOLAM	BENZODIAZEPINES	Message Only	753	$5,707.04	$7.58	$0.00	25.4	63.7	0	56	$241.66
10	METHADONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	657	$10,795.01	$16.43	$0.00	27.4	135.9	0	27	$523.53
All Others				32,347	$4,474,070.44	$138.31	$0.00	24.9	62.7	7,414	5,572	$720,213.34
TD - Therapeutic Duplication				42,122	$4,686,517.20	$111.26	$0.00	23.6	63.5	7,414	7,151	$733,453.43

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

Selected Filters

Client(s): Nevada Medicaid - HPES

Carrier(s): NVM-NEVADA MEDICAID

Account(s): ALL

Group(s): ALL

Date Type:	Date Filled Submitted
Primary Start Date:	Oct 1, 2014
Primary End Date:	Dec 31, 2014
Relative Date Description:	N/A
Select Report Group By:	Product
Top Values Displayed:	10
Display Report Description:	Yes

Report Description

Report overview:

This report will be used to track concurrent DURs. The subsequent information will also be used to assist clients in managing Hard Rejects, Soft Rejects as well as Message Only edits. Reversals are also included in the report.

Detail Line Description:

Column Name	Description
Summary Page:	
Claims Summary:	
RxCLAIM Status	The claims status associated with the RxCLAIM transaction. For this reoprt, a claim Status can be any one of the following values: P = Paid Status, X = Reversal Status, R = Rejected Status.
Total Rxs	The total number of Rxs.
% of Total Rxs	The percentage of the total number of Rxs.

Total Plan Paid	The Client Total Amount Due.
Total Member Paid	The Client Total Patient Pay Amount. The patient pay would include copays and all other charges paid by the member.

DUR Information Summary:

DUR Type	DUR Reason for Service Code and Description
Clinical Level	DUR (Drug Utilization Review). Indicates how significant the first conflict is. This field reflects the significance that the originating database assigned to it. 0 = Not specified, 1 = Major, 2 = Moderate, 3 = Minor
Total DURs	
Count	Total count of DUR edits. An Rx claim may have more than 1 DUR edit.
% of All DURs	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types.
DURs on Paid Rxs	
Count	Total count of DUR edits on paid Rx claims. A paid Rx claim may have more than 1 DUR edit.
% of DUR Type	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types on Paid Rx claims.
DURs on Rejected Rxs	
Count	Total count of DUR edits on rejected Rx claims. A rejected Rx claim may have more than 1 DUR edit.
% of DUR Type	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types on Rejected Rx claims.
DURs on Reversed Rxs	
Count	Total count of DUR edits on reversed Rx claims. A reversed Rx claim may have more than 1 DUR edit.
% of DUR Type	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types on Reversed Rx claims.

DUR Tabs:

Rank	Ranking is based on total number of Rxs (Paid + Rjected + Reversal) in descending order. A gap in sequence may occur if two or more rows tie (known as Olympic ranking).
Top Drug-Drug Interaction (DD Only)	Drug combination with a DD DUR code
Top Drug	Product Name
Therapy / Reason	DUR Free Text Message
DUR Response	DUR Responses are categorized as: H = Hard Reject, S = Soft Reject, any other code = Message Only
Total Paid Rxs	The total number of paid Rxs.
Total Plan Paid	The Client total amount due.
Avg Plan Paid / Rx	The average plan cost per Rx.

Avg Member Paid / Rx	The average member cost per Rx.
Avg Days Supply / Rx	The average days supply per Rx.
Avg Quantity / Rx	The average quantity per Rx.
Total Rejected Rxs	The total number of rejected Rxs.
Total Reversed Rxs	The total number of reversed Rxs.
Total Reversed Amount	The total amount of reversed Rxs.

No Patient Health Information

RXT6050D - Summarized DUR Activity Report

Between Jan 1, 2015 and Mar 31, 2015

Apr 17, 2015
11:10:54 AM

Claims Summary:

RxCLAIM Status	Total Rxs	% of Total Rxs	Total Plan Paid	Total Member Paid
Paid	744,386	64.3%	$67,607,153.67	$0.00
Rejected	326,676	28.2%	$42,019,371.85	$0.00
Reversed	86,795	7.5%	-$12,830,660.21	$0.00
Totals	1,157,857	100%	$96,795,865.31	$0.00

DUR Information Summary:

		Total DURs		DURs on Paid Rxs		DURs on Rejected Rxs		DURs on Reversed Rxs	
DUR Type	Clinical Level	Count	% of All DURs	Count	% of DUR Type	Count	% of DUR Type	Count	% of DUR Type
TD - Therapeutic Duplication	0 - NS	62,135	22.8%	46,275	74.5%	7,773	12.5%	8,087	13.0%
LR - Underuse Precaution	0 - NS	61,287	22.5%	55,775	91.0%	0	0.0%	5,512	9.0%
ID - Ingredient Duplication	2 - Mod	48,764	17.9%	12,790	26.2%	32,639	66.9%	3,335	6.8%
DD - Drug-Drug Interaction	1 - Maj	38,801	14.2%	31,849	82.1%	3,654	9.4%	3,298	8.5%
LD - Low Dose Alert	0 - NS	27,697	10.2%	23,265	84.0%	0	0.0%	4,432	16.0%
HD - High Dose Alert	0 - NS	19,278	7.1%	16,994	88.2%	190	1.0%	2,094	10.9%
MN - Insufficnt Duration Alert	0 - NS	9,370	3.4%	6,775	72.3%	0	0.0%	2,595	27.7%
MX - Excessive Duration Alert	0 - NS	5,371	2.0%	4,948	92.1%	0	0.0%	423	7.9%
PA - Drug-Age Precaution	1 - Maj	84	0.0%	78	92.9%	0	0.0%	6	7.1%
Total All DURs		272,787	100.0%	198,749	72.9%	44,256	16.2%	29,782	10.9%

* DUR Information Summary results are sorted by Total DUR count in descending order
* Some Rx claims could have multiple DUR messages. And there could be multiple instances of the same DUR message on a Rx claim
* The Count and % of DUR Type for Paid, Rejected and Reversed Rxs are based on DUR Type totals for each row

DD - Drug-Drug Interaction

Rank	Top Drug Drug Interaction	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	CARISOPRODOL - ALPRAZOLAM	Message Only	771	$5,428.97	$7.04	$0.00	28.9	77.5	88	41	$190.75
2	SIMVASTATIN - FENOFIBRATE	Message Only	456	$15,076.78	$33.06	$0.00	33.4	33.9	45	15	$449.04
3	OXYCODONE HCL - CARISOPRODOL	Message Only	414	$18,450.27	$44.57	$0.00	28.1	119.8	47	22	$924.34
4	OXYCODONE - CARISOPRODOL	Message Only	368	$3,270.05	$8.89	$0.00	29.3	85.1	87	14	$101.51
5	OXYCOD/APAP - CARISOPRODOL	Message Only	371	$2,567.58	$6.92	$0.00	29.0	77.0	61	32	$124.63
6	OXYCODONE/ACETAMINOPHEN - CARISOPRODOL	Message Only	399	$24,346.98	$61.02	$0.00	26.7	111.0	31	22	$956.64
7	TRAZODONE HCL - CITALOPRAM	Message Only	363	$2,466.65	$6.80	$0.00	29.9	37.2	48	23	$193.86
8	TRAZODONE HCL - QUETIAPINE	Message Only	370	$2,594.68	$7.01	$0.00	27.3	39.7	32	27	$308.04
9	SPIRONOLACT - LISINOPRIL	Message Only	308	$1,572.56	$5.11	$0.00	34.8	38.9	42	34	$72.04
10	TRAZODONE - QUETIAPINE FUMARATE	Message Only	316	$5,797.82	$18.35	$0.00	26.8	42.5	30	22	$352.43
All Others			27,713	$2,286,776.47	$82.52	$0.00	25.3	48.5	3,143	3,046	$426,948.22
DD - Drug-Drug Interaction			31,849	$2,368,348.81	$74.36	$0.00	25.9	51.0	3,654	3,298	$430,621.50

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

HD - High Dose Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	HYDROCODONE/ ACETAMINOPHEN	ADULT MAX DLY = 6.00 UN	Message Only	603	$20,613.41	$34.18	$0.00	15.8	124.7	0	27	$954.94
2	ZOLPIDEM TARTRATE	GERIATRIC MAX DLY = .50UN	Message Only	420	$970.16	$2.31	$0.00	30.3	30.3	0	25	$47.15
3	KETOROLAC TROMETHAMINE	GERIATRIC MAX DLY = 2.00UN	Message Only	243	$1,298.02	$5.34	$0.00	1.0	4.2	0	28	$157.10
4	INVEGA SUSTENNA	ADULT MAX DLY = .05 UN	Message Only	213	$347,933.72	$1,633.49	$0.00	26.8	1.5	0	7	$11,211.22
5	PROMETHAZINE/ CODEINE	ADULT MAX DLY = 30.00 UN	Message Only	193	$1,411.34	$7.31	$0.00	3.2	138.7	0	16	$112.39
6	GRANISETRON HCL	GERIATRIC MAX DLY = .85UN	Message Only	198	$3,310.69	$16.72	$0.00	1.0	1.1	0	7	$71.40
7	MIDAZOLAM HCL	GERIATRIC MAX DLY = .70UN	Message Only	188	$791.16	$4.21	$0.00	1.0	4.7	0	5	$7.38
8	ONDANSETRON ODT	ADULT MAX DLY = 3.00 UN	Message Only	157	$3,988.02	$25.40	$0.00	6.7	25.7	0	29	$804.04
9	CEFTRIAXONE SODIUM	GERIATRIC MAX DLY = 2.00UN	Message Only	176	$46,291.70	$263.02	$0.00	1.0	231.1	0	9	$243.90
10	TAMIFLU	PEDIATRIC MAX DLY = 20.00UN	Message Only	160	$40,517.33	$253.23	$0.00	5.1	124.7	0	15	$3,574.10
All Others				14,443	$3,133,802.14	$216.98	$0.00	14.2	122.3	190	1,926	$768,587.17
HD - High Dose Alert				16,994	$3,600,927.69	$211.89	$0.00	13.9	114.7	190	2,094	$785,770.79

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

ID - Ingredient Duplication

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	HYDROCODONE/ ACETAMINOPHEN	HYDROCO/APAP TAB 10-325MG	Hard Reject	4	$98.15	$24.54	$0.00	13.5	67.5	1,089	1	$32.65
2	SODIUM CHLORIDE	SOD CHLORIDE INJ 0.9%	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	725	0	$0.00
3	OXYCODONE/ ACETAMINOPHEN	OXYCOD/APAP TAB 10-325MG	Hard Reject	3	$123.45	$41.15	$0.00	16.3	56.7	581	0	$0.00
4	ZOLPIDEM TARTRATE	ZOLPIDEM TAB 10MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	471	0	$0.00
5	ALPRAZOLAM	ALPRAZOLAM TAB 1MG	Hard Reject	2	$14.79	$7.40	$0.00	18.5	55.5	460	0	$0.00
6	ALPRAZOLAM	ALPRAZOLAM TAB 2MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	421	0	$0.00
7	PROAIR HFA	PROAIR HFA AER	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	376	0	$0.00
8	TRAMADOL HCL	TRAMADOL HCL TAB 50MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	318	0	$0.00
9	GABAPENTIN	GABAPENTIN CAP 300MG	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	310	0	$0.00
10	CLONAZEPAM	CLONAZEPAM TAB 1MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	288	0	$0.00
All Others				12,781	$3,025,478.23	$236.72	$0.00	27.0	162.0	27,600	3,334	$468,407.47
ID - Ingredient Duplication				12,790	$3,025,714.62	$236.57	$0.00	27.0	161.9	32,639	3,335	$468,440.12

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

LD - Low Dose Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	ONDANSETRON HCL	GERIATRIC MIN DLY = 2.00UN	Message Only	1,067	$334.50	$0.31	$0.00	1.3	1.2	0	665	$171.83
2	ONDANSETRON ODT	GERIATRIC MIN DLY = 2.00UN	Message Only	691	$527.64	$0.76	$0.00	1.2	1.2	0	226	$160.84
3	IPRATROPIUM BROMIDE/ALBUT	GERIATRIC MIN DLY = 12.00UN	Message Only	564	$1,175.69	$2.08	$0.00	3.1	13.3	0	225	$187.11
4	ZOFRAN ODT	GERIATRIC MIN DLY = 2.00UN	Message Only	383	$8,046.74	$21.01	$0.00	1.0	1.0	0	151	$3,213.43
5	METFORMIN HCL	ADULT MIN DLY = 1.70 UN	Message Only	484	$2,498.86	$5.16	$0.00	32.1	31.6	0	43	$220.39
6	ALBUTEROL SULFATE	GERIATRIC MIN DLY = 9.00UN	Message Only	412	$299.70	$0.73	$0.00	3.6	17.2	0	84	$77.56
7	VITAMIN D	ADULT MIN DLY = .14 UN	Message Only	427	$2,623.88	$6.14	$0.00	33.0	2.9	0	37	$213.63
8	GABAPENTIN	ADULT MIN DLY = 3.00 UN	Message Only	380	$2,650.89	$6.98	$0.00	33.1	54.0	0	27	$180.01
9	CITALOPRAM HYDROBROMIDE	ADULT MIN DLY = 2.00 UN	Message Only	367	$2,182.90	$5.95	$0.00	29.7	29.7	0	27	$140.72
10	ONDANSETRON HCL	GERIATRIC MIN DLY = 10.00UN	Message Only	192	$384.26	$2.00	$0.00	1.0	1.3	0	167	$321.43
All Others				18,298	$1,765,519.95	$96.49	$0.00	24.5	54.0	0	2,780	$333,321.05
LD - Low Dose Alert				23,265	$1,786,245.01	$76.78	$0.00	21.8	45.3	0	4,432	$338,208.00

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

LR - Underuse Precaution

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	LISINOPRIL	7 DAYS LATE REFILLING	Message Only	82	$425.81	$5.19	$0.00	30.8	35.3	0	6	$19.80
2	AMLODIPINE BESYLATE	7 DAYS LATE REFILLING	Message Only	67	$279.57	$4.17	$0.00	29.2	29.6	0	4	$20.28
3	LISINOPRIL	8 DAYS LATE REFILLING	Message Only	67	$396.61	$5.92	$0.00	30.0	36.3	0	1	$6.69
4	ATORVASTATIN CALCIUM	7 DAYS LATE REFILLING	Message Only	57	$650.16	$11.41	$0.00	29.2	29.2	0	5	$69.38
5	SIMVASTATIN	7 DAYS LATE REFILLING	Message Only	57	$324.60	$5.69	$0.00	30.1	30.9	0	1	$7.94
6	METFORMIN HCL	7 DAYS LATE REFILLING	Message Only	53	$280.57	$5.29	$0.00	29.7	62.7	0	4	$35.21
7	AMLODIPINE BESYLATE	8 DAYS LATE REFILLING	Message Only	52	$297.99	$5.73	$0.00	29.8	30.9	0	4	$25.07
8	LEVOTHYROXINE SODIUM	7 DAYS LATE REFILLING	Message Only	51	$417.49	$8.19	$0.00	29.5	28.6	0	4	$56.93
9	MONTELUKAST SODIUM	7 DAYS LATE REFILLING	Message Only	50	$1,720.74	$34.41	$0.00	30.0	30.6	0	4	$94.82
9	PROAIR HFA	7 DAYS LATE REFILLING	Message Only	52	$2,522.84	$48.52	$0.00	23.3	9.2	0	2	$108.67
All Others				55,187	$4,788,348.10	$86.77	$0.00	28.6	50.1	0	5,477	$694,729.08
LR - Underuse Precaution				55,775	$4,795,664.48	$85.98	$0.00	28.6	49.9	0	5,512	$695,173.87

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

MN - Insufficnt Duration Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	IPRATROPIUM BROMIDE/ALBUT	MIN. DAYS THERAPY = 30	Message Only	446	$12,647.69	$28.36	$0.00	9.3	141.7	0	39	$736.11
2	LISINOPRIL	MIN. DAYS THERAPY = 7	Message Only	216	$58.73	$0.27	$0.00	1.1	1.4	0	161	$11.00
3	METOPROLOL TARTRATE	MIN. DAYS THERAPY = 7	Message Only	216	$67.31	$0.31	$0.00	1.2	2.1	0	139	$7.89
4	PANTOPRAZOLE SODIUM	MIN. DAYS THERAPY = 7	Message Only	170	$67.01	$0.39	$0.00	1.1	1.2	0	148	$38.18
5		ING01 MIN DAYS THERAPY = 5	Message Only	261	$27,349.60	$104.79	$0.00	1.5	85.4	0	25	$1,769.00
6	CLONIDINE HCL	MIN. DAYS THERAPY = 7	Message Only	198	$202.96	$1.03	$0.00	1.6	5.0	0	78	$12.37
7	BROMPHEN/ PSEUDOEPHEDRINE	MIN. DAYS THERAPY = 7	Message Only	218	$5,506.80	$25.26	$0.00	4.9	118.2	0	15	$432.76
8	SULFAMETHOXAZOLE/ TRIMETHO	MIN. DAYS THERAPY = 5	Message Only	196	$556.96	$2.84	$0.00	2.1	5.9	0	36	$10.95
9	LEVETIRACETAM	MIN. DAYS THERAPY = 14	Message Only	208	$2,137.45	$10.28	$0.00	6.8	38.0	0	22	$158.69
10	LEVOTHYROXINE SODIUM	MIN. DAYS THERAPY = 10	Message Only	204	$845.81	$4.15	$0.00	6.2	6.2	0	16	$19.49
All Others				4,442	$251,500.76	$56.62	$0.00	3.0	15.7	0	1,916	$38,826.12
MN - Insufficnt Duration Alert				6,775	$300,941.08	$44.42	$0.00	3.4	28.5	0	2,595	$42,022.56

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

MX - Excessive Duration Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	CYCLOBENZAPRINE HCL	MAX DAYS THERAPY = 21	Message Only	2,524	$18,943.02	$7.51	$0.00	30.1	64.9	0	142	$1,240.18
2	AZITHROMYCIN	MAX DAYS THERAPY = 5	Message Only	333	$8,044.26	$24.16	$0.00	10.6	20.6	0	29	$1,709.35
3	FLUCONAZOLE	MAX DAYS THERAPY = 1	Message Only	202	$2,326.55	$11.52	$0.00	3.4	3.5	0	6	$53.47
4	DIPHENOXYLATE/ ATROPINE	MAX DAYS THERAPY = 14	Message Only	131	$2,869.76	$21.91	$0.00	24.9	116.2	0	6	$150.51
5	EPIPEN 2-PAK	MAX DAYS THERAPY = 1	Message Only	120	$49,515.48	$412.63	$0.00	2.2	2.2	0	14	$6,614.50
6	MAPAP	MAX DAYS THERAPY = 10	Message Only	122	$671.97	$5.51	$0.00	26.6	96.2	0	9	$52.86
7	CEFDINIR	MAX DAYS THERAPY = 10	Message Only	112	$6,232.44	$55.65	$0.00	15.9	71.5	0	8	$247.37
8	TRAMADOL HYDROCHLORIDE/AC	MAX DAYS THERAPY = 5	Message Only	113	$2,066.93	$18.29	$0.00	19.9	81.9	0	6	$136.35
9	POLYETHYLENE GLYCOL 3350	MAX DAYS THERAPY = 14	Message Only	87	$2,290.66	$26.33	$0.00	30.5	30.5	0	16	$420.57
10	DOCUSATE SODIUM & SENNA S	MAX DAYS THERAPY = 14	Message Only	83	$473.40	$5.70	$0.00	29.2	58.5	0	7	$34.36
All Others				1,121	$205,162.43	$183.02	$0.00	25.6	69.6	0	180	$64,880.96
MX - Excessive Duration Alert				4,948	$298,596.90	$60.35	$0.00	25.2	60.9	0	423	$75,540.48

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

PA - Drug-Age Precaution

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	PROMETHAZINE-DM	AGE LESS THAN 4	Message Only	25	$179.16	$7.17	$0.00	10.8	104.6	0	1	$4.00
2	PROMETHAZINE/ DEXTROMETHOR	AGE LESS THAN 4	Message Only	23	$134.36	$5.84	$0.00	9.5	80.2	0	0	$0.00
3	PROMETHAZINE HCL PLAIN	AGE LESS THAN 4	Message Only	11	$76.54	$6.96	$0.00	9.0	109.5	0	3	$20.25
4	PROMETHAZINE/CODEINE	AGE LESS THAN 4	Message Only	10	$64.40	$6.44	$0.00	8.8	90.0	0	0	$0.00
5	PROMETHAZINE HCL	AGE LESS THAN 4	Message Only	5	$46.15	$9.23	$0.00	10.6	93.4	0	0	$0.00
6	PHENADOZ	AGE LESS THAN 4	Message Only	2	$26.10	$13.05	$0.00	3.0	8.0	0	1	$15.12
7	PROMETHEGAN	AGE LESS THAN 4	Message Only	1	$10.53	$10.53	$0.00	3.0	6.0	0	1	$7.64
8	PROMETHAZINE VC/CODEINE	AGE LESS THAN 4	Message Only	1	$21.20	$21.20	$0.00	8.0	80.0	0	0	$0.00
PA - Drug-Age Precaution				78	$558.44	$7.16	$0.00	9.6	91.4	0	6	$47.01

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

TD - Therapeutic Duplication

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	HYDROCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,715	$33,704.76	$19.65	$0.00	17.5	71.8	0	193	$1,540.75
2	HYDROMORPHONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	945	$5,360.49	$5.67	$0.00	5.0	18.1	0	494	$1,352.92
3	OXYCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,198	$46,270.74	$38.62	$0.00	14.5	61.1	0	200	$4,645.45
4	QUETIAPINE FUMARATE	ORAL ANTIPSYCHOTICS	Message Only	1,144	$23,510.60	$20.55	$0.00	27.3	41.4	0	86	$1,715.43
5	OXYCODONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,103	$52,771.21	$47.84	$0.00	22.9	105.4	0	101	$2,265.42
6	MORPHINE SULFATE	SHORT ACTING NARCOTIC ANALGESI	Message Only	726	$3,852.12	$5.31	$0.00	5.8	19.3	0	398	$930.88
7	TRAMADOL HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	887	$7,568.64	$8.53	$0.00	20.5	86.4	0	65	$370.60
8	RISPERIDONE	ORAL ANTIPSYCHOTICS	Message Only	810	$11,622.84	$14.35	$0.00	26.3	43.0	0	53	$631.53
9	ALPRAZOLAM	BENZODIAZEPINES	Message Only	745	$5,518.42	$7.41	$0.00	25.4	64.1	0	69	$314.23
10	LISINOPRIL	ANGIOTENSIN BLOCKERS	Message Only	598	$2,574.65	$4.31	$0.00	33.9	39.6	0	137	$286.14
All Others				36,404	$4,203,792.62	$115.48	$0.00	24.5	58.4	7,773	6,291	$652,303.25
TD - Therapeutic Duplication				46,275	$4,396,547.09	$95.01	$0.00	23.4	58.4	7,773	8,087	$666,356.60

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

Selected Filters

Client(s): Nevada Medicaid - HPES

Carrier(s): NVM-NEVADA MEDICAID

Account(s): ALL

Group(s): ALL

Date Type:	Date Filled Submitted
Primary Start Date:	Jan 1, 2015
Primary End Date:	Mar 31, 2015
Relative Date Description:	Previous Quarter
Select Report Group By:	Product
Top Values Displayed:	10
Display Report Description:	Yes

Report Description

Report overview:

This report will be used to track concurrent DURs. The subsequent information will also be used to assist clients in managing Hard Rejects, Soft Rejects as well as Message Only edits. Reversals are also included in the report.

Detail Line Description:

Column Name	Description
Summary Page:	
Claims Summary:	
RxCLAIM Status	The claims status associated with the RxCLAIM transaction. For this reoprt, a claim Status can be any one of the following values: P = Paid Status, X = Reversal Status, R = Rejected Status.
Total Rxs	The total number of Rxs.
% of Total Rxs	The percentage of the total number of Rxs.

Total Plan Paid	The Client Total Amount Due.
Total Member Paid	The Client Total Patient Pay Amount. The patient pay would include copays and all other charges paid by the member.

DUR Information Summary:

DUR Type	DUR Reason for Service Code and Description
Clinical Level	DUR (Drug Utilization Review). Indicates how significant the first conflict is. This field reflects the significance that the originating database assigned to it. 0 = Not specified, 1 = Major, 2 = Moderate, 3 = Minor
Total DURs	
Count	Total count of DUR edits. An Rx claim may have more than 1 DUR edit.
% of All DURs	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types.
DURs on Paid Rxs	
Count	Total count of DUR edits on paid Rx claims. A paid Rx claim may have more than 1 DUR edit.
% of DUR Type	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types on Paid Rx claims.
DURs on Rejected Rxs	
Count	Total count of DUR edits on rejected Rx claims. A rejected Rx claim may have more than 1 DUR edit.
% of DUR Type	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types on Rejected Rx claims.
DURs on Reversed Rxs	
Count	Total count of DUR edits on reversed Rx claims. A reversed Rx claim may have more than 1 DUR edit.
% of DUR Type	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types on Reversed Rx claims.

DUR Tabs:

Rank	Ranking is based on total number of Rxs (Paid + Rjected + Reversal) in descending order. A gap in sequence may occur if two or more rows tie (known as Olympic ranking).
Top Drug-Drug Interaction (DD Only)	Drug combination with a DD DUR code
Top Drug	Product Name
Therapy / Reason	DUR Free Text Message
DUR Response	DUR Responses are categorized as: H = Hard Reject, S = Soft Reject, any other code = Message Only
Total Paid Rxs	The total number of paid Rxs.
Total Plan Paid	The Client total amount due.
Avg Plan Paid / Rx	The average plan cost per Rx.

Avg Member Paid / Rx	The average member cost per Rx.
Avg Days Supply / Rx	The average days supply per Rx.
Avg Quantity / Rx	The average quantity per Rx.
Total Rejected Rxs	The total number of rejected Rxs.
Total Reversed Rxs	The total number of reversed Rxs.
Total Reversed Amount	The total amount of reversed Rxs.

No Patient Health Information

RXT6050D - Summarized DUR Activity Report

Between Apr 1, 2015 and Jun 30, 2015

Aug 18, 2015
1:08:46 PM

Claims Summary:

RxCLAIM Status	Total Rxs	% of Total Rxs	Total Plan Paid	Total Member Paid
Paid	738,432	63.6%	$67,986,735.51	$0.00
Rejected	328,339	28.3%	$44,735,237.29	$0.00
Reversed	94,965	8.2%	-$16,387,670.36	$0.00
Totals	1,161,736	100%	$96,334,302.44	$0.00

DUR Information Summary:

		Total DURs		DURs on Paid Rxs		DURs on Rejected Rxs		DURs on Reversed Rxs	
DUR Type	Clinical Level	Count	% of All DURs	Count	% of DUR Type	Count	% of DUR Type	Count	% of DUR Type
LR - Underuse Precaution	0 - NS	61,751	22.8%	55,515	89.9%	0	0.0%	6,236	10.1%
TD - Therapeutic Duplication	0 - NS	61,737	22.8%	45,484	73.7%	7,631	12.4%	8,622	14.0%
ID - Ingredient Duplication	2 - Mod	47,458	17.5%	12,390	26.1%	31,613	66.6%	3,455	7.3%
DD - Drug-Drug Interaction	1 - Maj	37,972	14.0%	31,018	81.7%	3,531	9.3%	3,423	9.0%
LD - Low Dose Alert	0 - NS	27,238	10.1%	22,450	82.4%	0	0.0%	4,788	17.6%
HD - High Dose Alert	0 - NS	18,847	7.0%	16,652	88.4%	151	0.8%	2,044	10.8%
MN - Insufficnt Duration Alert	0 - NS	10,076	3.7%	7,025	69.7%	0	0.0%	3,051	30.3%
MX - Excessive Duration Alert	0 - NS	5,326	2.0%	4,917	92.3%	0	0.0%	409	7.7%
PA - Drug-Age Precaution	1 - Maj	34	0.0%	33	97.1%	0	0.0%	1	2.9%
Total All DURs		270,439	100.0%	195,484	72.3%	42,926	15.9%	32,029	11.8%

* DUR Information Summary results are sorted by Total DUR count in descending order
* Some Rx claims could have multiple DUR messages. And there could be multiple instances of the same DUR message on a Rx claim
* The Count and % of DUR Type for Paid, Rejected and Reversed Rxs are based on DUR Type totals for each row

DD - Drug-Drug Interaction

Rank	Top Drug Drug Interaction	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	CARISOPRODOL - ALPRAZOLAM	Message Only	717	$5,192.88	$7.24	$0.00	28.9	77.4	110	25	$115.37
2	SIMVASTATIN - FENOFIBRATE	Message Only	440	$10,447.94	$23.75	$0.00	33.5	34.2	58	27	$973.98
3	TRAZODONE HCL - QUETIAPINE	Message Only	430	$2,628.28	$6.11	$0.00	27.4	38.4	49	24	$199.31
4	TRAZODONE HCL - CITALOPRAM	Message Only	374	$2,618.44	$7.00	$0.00	30.4	39.3	52	26	$139.18
5	TRAZODONE - QUETIAPINE FUMARATE	Message Only	356	$7,610.08	$21.38	$0.00	28.2	45.0	35	20	$321.34
6	TRAZODONE - CITALOPRAM HYDROBROMIDE	Message Only	344	$1,846.09	$5.37	$0.00	30.4	32.1	35	25	$151.67
7	METHADONE - ALPRAZOLAM	Message Only	330	$2,810.30	$8.52	$0.00	26.2	71.2	30	9	$70.25
7	SPIRONOLACT - LISINOPRIL	Message Only	315	$1,704.69	$5.41	$0.00	37.6	43.6	33	21	$78.81
9	SPIRONOLACTONE - LISINOPRIL	Message Only	277	$2,834.01	$10.23	$0.00	37.1	40.5	29	18	$78.77
10	SIMVASTATIN - AMLODIPINE BESYLATE	Message Only	263	$1,089.18	$4.14	$0.00	35.4	36.7	35	14	$56.23
All Others			27,172	$2,893,990.62	$106.51	$0.00	25.4	51.0	3,065	3,214	$795,511.45
DD - Drug-Drug Interaction			31,018	$2,932,772.51	$94.55	$0.00	26.1	50.7	3,531	3,423	$797,696.36

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

HD - High Dose Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	HYDROCODONE/ ACETAMINOPHEN	ADULT MAX DLY = 6.00 UN	Message Only	631	$22,026.96	$34.91	$0.00	16.6	131.5	0	27	$993.17
2	KETOROLAC TROMETHAMINE	GERIATRIC MAX DLY = 2.00UN	Message Only	609	$4,573.39	$7.51	$0.00	1.0	4.2	0	34	$266.73
3	ZOLPIDEM TARTRATE	GERIATRIC MAX DLY = .50UN	Message Only	377	$1,130.06	$3.00	$0.00	30.2	30.2	0	16	$27.19
4	GRANISETRON HCL	GERIATRIC MAX DLY = .85UN	Message Only	246	$5,937.14	$24.13	$0.00	1.0	1.1	0	5	$57.63
5	IBUPROFEN	ADULT MAX DLY = 4.00 UN	Message Only	205	$1,215.61	$5.93	$0.00	6.6	31.8	0	8	$47.67
6	MIDAZOLAM HCL	GERIATRIC MAX DLY = 3.50UN	Message Only	159	$344.81	$2.17	$0.00	1.0	5.3	0	36	$97.24
7	INVEGA SUSTENNA	ADULT MAX DLY = .05 UN	Message Only	182	$319,615.39	$1,756.13	$0.00	26.1	1.5	0	9	$16,533.94
8	KENALOG-40	GERIATRIC MAX DLY = 2.00UN	Message Only	182	$5,574.08	$30.63	$0.00	1.0	6.1	0	1	$26.44
9	CELESTONE-SOLUSPAN	GERIATRIC MAX DLY = 1.50UN	Message Only	168	$3,813.51	$22.70	$0.00	1.0	3.9	0	10	$360.10
10	CEFTRIAXONE SODIUM	GERIATRIC MAX DLY = 4.00UN	Message Only	145	$16,763.99	$115.61	$0.00	1.0	182.8	0	31	$1,398.33
All Others				13,748	$3,646,978.17	$265.27	$0.00	14.5	188.1	151	1,867	$822,539.12
HD - High Dose Alert				16,652	$4,027,973.11	$241.89	$0.00	13.8	163.3	151	2,044	$842,347.56

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

ID - Ingredient Duplication

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	HYDROCODONE/ ACETAMINOPHEN	HYDROCO/APAP TAB 10-325MG	Hard Reject	2	$74.59	$37.30	$0.00	30.0	105.0	901	0	$0.00
2	SODIUM CHLORIDE	SOD CHLORIDE INJ 0.9%	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	677	0	$0.00
3	OXYCODONE/ ACETAMINOPHEN	OXYCOD/APAP TAB 10-325MG	Hard Reject	4	$271.11	$67.78	$0.00	19.5	78.0	473	0	$0.00
4	ZOLPIDEM TARTRATE	ZOLPIDEM TAB 10MG	Hard Reject	1	$5.78	$5.78	$0.00	30.0	30.0	459	0	$0.00
5	ALPRAZOLAM	ALPRAZOLAM TAB 1MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	406	0	$0.00
6	TRAMADOL HCL	TRAMADOL HCL TAB 50MG	Hard Reject	1	$6.17	$6.17	$0.00	15.0	30.0	356	0	$0.00
7	GABAPENTIN	GABAPENTIN CAP 300MG	Soft Reject	1	$7.03	$7.03	$0.00	30.0	30.0	350	0	$0.00
8	PROAIR HFA	PROAIR HFA AER	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	345	0	$0.00
9	ALPRAZOLAM	ALPRAZOLAM TAB 2MG	Hard Reject	2	$23.44	$11.72	$0.00	18.5	59.5	328	1	$8.39
10	GABAPENTIN	GABAPENTIN CAP 300MG	Message Only	228	$2,480.27	$10.88	$0.00	31.2	97.3	0	54	$563.42
All Others				12,151	$1,810,595.99	$149.01	$0.00	26.8	97.9	27,318	3,400	$529,811.08
ID - Ingredient Duplication				12,390	$1,813,464.38	$146.37	$0.00	26.9	97.9	31,613	3,455	$530,382.89

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

LD - Low Dose Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	ONDANSETRON HCL	GERIATRIC MIN DLY = 2.00UN	Message Only	1,272	$526.49	$0.41	$0.00	1.4	1.4	0	882	$263.39
2	ONDANSETRON ODT	GERIATRIC MIN DLY = 2.00UN	Message Only	608	$482.08	$0.79	$0.00	1.2	1.1	0	188	$139.18
3	IPRATROPIUM BROMIDE/ALBUT	GERIATRIC MIN DLY = 12.00UN	Message Only	472	$831.83	$1.76	$0.00	2.4	12.6	0	230	$291.48
4	ZOFRAN ODT	GERIATRIC MIN DLY = 2.00UN	Message Only	449	$9,481.94	$21.12	$0.00	1.0	1.0	0	186	$3,948.66
5	METFORMIN HCL	ADULT MIN DLY = 1.70 UN	Message Only	489	$2,539.80	$5.19	$0.00	33.4	33.2	0	46	$243.96
6	VITAMIN D	ADULT MIN DLY = .14 UN	Message Only	447	$2,721.30	$6.09	$0.00	31.3	3.1	0	27	$155.15
7	CITALOPRAM HYDROBROMIDE	ADULT MIN DLY = 2.00 UN	Message Only	359	$2,076.40	$5.78	$0.00	29.1	29.1	0	40	$232.62
8	GABAPENTIN	ADULT MIN DLY = 3.00 UN	Message Only	357	$2,546.17	$7.13	$0.00	32.2	53.3	0	37	$273.91
9	ALBUTEROL SULFATE	GERIATRIC MIN DLY = 9.00UN	Message Only	321	$167.62	$0.52	$0.00	2.5	11.3	0	59	$52.62
10	ONDANSETRON HCL	ADULT MIN DLY = 2.00 UN	Message Only	263	$1,993.29	$7.58	$0.00	18.2	12.0	0	30	$227.07
All Others				17,413	$1,281,587.82	$73.60	$0.00	24.0	54.2	0	3,063	$293,696.97
LD - Low Dose Alert				22,450	$1,304,954.74	$58.13	$0.00	21.3	44.9	0	4,788	$299,525.01

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

LR - Underuse Precaution

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	LISINOPRIL	7 DAYS LATE REFILLING	Message Only	90	$467.66	$5.20	$0.00	29.5	33.2	0	5	$19.21
2	LEVOTHYROXINE SODIUM	7 DAYS LATE REFILLING	Message Only	73	$555.37	$7.61	$0.00	29.6	29.2	0	4	$33.42
3	AMLODIPINE BESYLATE	7 DAYS LATE REFILLING	Message Only	66	$332.87	$5.04	$0.00	29.4	31.2	0	4	$19.50
4	LISINOPRIL	8 DAYS LATE REFILLING	Message Only	57	$312.25	$5.48	$0.00	29.7	32.4	0	4	$12.14
5	PROAIR HFA	6 DAYS LATE REFILLING	Message Only	54	$2,255.82	$41.77	$0.00	22.1	8.5	0	5	$226.72
5	LEVOTHYROXINE SODIUM	8 DAYS LATE REFILLING	Message Only	53	$478.97	$9.04	$0.00	29.6	30.2	0	6	$77.02
7	SIMVASTATIN	7 DAYS LATE REFILLING	Message Only	51	$303.73	$5.96	$0.00	29.0	29.0	0	5	$27.76
7	AMLODIPINE BESYLATE	8 DAYS LATE REFILLING	Message Only	54	$274.48	$5.08	$0.00	30.7	31.2	0	2	$7.30
9	LISINOPRIL	11 DAYS LATE REFILLING	Message Only	54	$290.01	$5.37	$0.00	29.7	31.1	0	1	$1.20
10	LISINOPRIL	9 DAYS LATE REFILLING	Message Only	46	$220.05	$4.78	$0.00	30.0	31.3	0	8	$41.26
All Others				54,917	$4,723,055.66	$86.00	$0.00	28.7	49.8	0	6,192	$781,011.77
LR - Underuse Precaution				55,515	$4,728,546.87	$85.18	$0.00	28.7	49.5	0	6,236	$781,477.30

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

MN - Insufficnt Duration Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	LISINOPRIL	MIN. DAYS THERAPY = 7	Message Only	324	$92.39	$0.29	$0.00	1.1	1.5	0	232	$32.03
2	IPRATROPIUM BROMIDE/ALBUT	MIN. DAYS THERAPY = 30	Message Only	400	$11,056.92	$27.64	$0.00	9.5	144.3	0	56	$1,001.19
3	METOPROLOL TARTRATE	MIN. DAYS THERAPY = 7	Message Only	248	$61.91	$0.25	$0.00	1.1	1.8	0	153	$6.78
4	CLONIDINE HCL	MIN. DAYS THERAPY = 7	Message Only	218	$196.36	$0.90	$0.00	1.5	4.5	0	111	$21.80
5	LEVETIRACETAM	MIN. DAYS THERAPY = 14	Message Only	223	$2,211.59	$9.92	$0.00	6.2	28.8	0	40	$366.89
6	ATORVASTATIN CALCIUM	MIN. DAYS THERAPY = 7	Message Only	148	$102.93	$0.70	$0.00	1.2	1.3	0	98	$43.76
7	INVANZ	MIN. DAYS THERAPY = 3	Message Only	156	$11,568.99	$74.16	$0.00	1.0	1.0	0	84	$6,605.47
8	SULFAMETHOXAZOLE/ TRIMETHO	MIN. DAYS THERAPY = 5	Message Only	184	$491.22	$2.67	$0.00	1.9	6.3	0	38	$39.02
9	FERROUS SULFATE	MIN. DAYS THERAPY = 30	Message Only	165	$766.02	$4.64	$0.00	14.3	26.1	0	56	$23.56
10		ING01 MIN DAYS THERAPY = 5	Message Only	184	$13,723.09	$74.58	$0.00	1.4	146.9	0	36	$1,694.85
All Others				4,775	$268,318.94	$56.19	$0.00	2.6	15.0	0	2,147	$56,919.31
MN - Insufficnt Duration Alert				7,025	$308,590.36	$43.93	$0.00	3.1	24.3	0	3,051	$66,754.66

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

MX - Excessive Duration Alert

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	CYCLOBENZAPRINE HCL	MAX DAYS THERAPY = 21	Message Only	2,595	$19,814.18	$7.64	$0.00	30.1	64.6	0	139	$998.27
2	AZITHROMYCIN	MAX DAYS THERAPY = 5	Message Only	227	$4,854.12	$21.38	$0.00	11.8	18.6	0	11	$1,168.49
3	FLUCONAZOLE	MAX DAYS THERAPY = 1	Message Only	201	$2,551.76	$12.70	$0.00	3.4	3.4	0	9	$159.34
4	EPIPEN 2-PAK	MAX DAYS THERAPY = 1	Message Only	161	$72,379.11	$449.56	$0.00	2.2	2.2	0	22	$10,940.93
5	DIPHENOXYLATE/ ATROPINE	MAX DAYS THERAPY = 14	Message Only	138	$3,008.26	$21.80	$0.00	25.9	111.2	0	11	$209.88
6	MAPAP	MAX DAYS THERAPY = 10	Message Only	125	$691.28	$5.53	$0.00	26.0	95.8	0	11	$62.90
7	TRAMADOL HYDROCHLORIDE/AC	MAX DAYS THERAPY = 5	Message Only	103	$1,748.82	$16.98	$0.00	18.0	77.8	0	11	$137.11
8	POLYETHYLENE GLYCOL 3350	MAX DAYS THERAPY = 14	Message Only	94	$2,670.47	$28.41	$0.00	28.8	28.8	0	14	$297.26
9	DOCUSATE SODIUM & SENNA S	MAX DAYS THERAPY = 14	Message Only	85	$450.59	$5.30	$0.00	29.9	54.6	0	7	$41.31
10	SENEXON-S	MAX DAYS THERAPY = 14	Message Only	82	$488.55	$5.96	$0.00	31.2	62.7	0	7	$50.48
All Others				1,106	$230,016.43	$207.97	$0.00	25.1	69.3	0	167	$51,552.93
MX - Excessive Duration Alert				4,917	$338,673.57	$68.88	$0.00	25.6	60.5	0	409	$65,618.90

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

PA - Drug-Age Precaution

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	PROMETHAZINE-DM	AGE LESS THAN 4	Message Only	13	$89.30	$6.87	$0.00	13.2	118.1	0	0	$0.00
2	PROMETHAZINE/ DEXTROMETHOR	AGE LESS THAN 4	Message Only	9	$52.34	$5.82	$0.00	8.9	68.3	0	0	$0.00
3	PROMETHAZINE HCL	AGE LESS THAN 4	Message Only	6	$42.72	$7.12	$0.00	10.2	99.2	0	0	$0.00
4	PROMETHAZINE HCL PLAIN	AGE LESS THAN 4	Message Only	4	$29.48	$7.37	$0.00	7.8	125.0	0	1	$4.00
5	PROMETHAZINE/CODEINE	AGE LESS THAN 4	Message Only	1	$7.00	$7.00	$0.00	16.0	120.0	0	0	$0.00
PA - Drug-Age Precaution				33	$220.84	$6.69	$0.00	10.9	102.0	0	1	$4.00

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

TD - Therapeutic Duplication

Rank	Top Drug	Therapy / Reason	DUR Response	Total Paid Rxs	Total Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx	Total Rejected Rxs	Total Reversed Rxs	Total Reversed Amount
1	HYDROCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,624	$29,589.23	$18.22	$0.00	16.8	67.2	0	189	$1,382.44
2	OXYCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,235	$44,752.68	$36.24	$0.00	13.6	55.1	0	215	$2,008.84
3	HYDROMORPHONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	908	$5,249.10	$5.78	$0.00	4.9	17.3	0	519	$1,815.38
4	QUETIAPINE FUMARATE	ORAL ANTIPSYCHOTICS	Message Only	1,115	$23,303.14	$20.90	$0.00	26.9	41.3	0	81	$1,208.72
5	MORPHINE SULFATE	SHORT ACTING NARCOTIC ANALGESI	Message Only	736	$3,758.34	$5.11	$0.00	5.2	17.9	0	425	$1,163.43
6	OXYCODONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	995	$42,443.69	$42.66	$0.00	22.8	104.1	0	95	$2,305.96
7	RISPERIDONE	ORAL ANTIPSYCHOTICS	Message Only	855	$12,532.23	$14.66	$0.00	26.8	44.1	0	57	$718.92
8	TRAMADOL HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	824	$6,695.58	$8.13	$0.00	20.7	87.3	0	73	$270.47
9	LORAZEPAM	BENZODIAZEPINES	Message Only	597	$1,937.29	$3.25	$0.00	10.6	23.7	0	235	$224.02
10	ALPRAZOLAM	BENZODIAZEPINES	Message Only	749	$5,385.56	$7.19	$0.00	25.5	61.4	0	65	$254.62
All Others				35,846	$4,277,334.69	$119.33	$0.00	24.9	59.2	7,631	6,668	$717,800.94
TD - Therapeutic Duplication				45,484	$4,452,981.53	$97.90	$0.00	23.4	58.2	7,631	8,622	$729,153.74

* Rankings are based on the following order: Total Rxs (Paid + Rejected + Reversed) descending, total Rejected Rxs descending and Top Drug/Client Rider ascending.

Selected Filters

Client(s): Nevada Medicaid - HPES

Carrier(s): NVM-NEVADA MEDICAID

Account(s): ALL

Group(s): ALL

Date Type:	Date Filled Submitted
Primary Start Date:	Apr 1, 2015
Primary End Date:	Jun 30, 2015
Relative Date Description:	N/A
Select Report Group By:	Product
Top Values Displayed:	10
Display Report Description:	Yes

Report Description

Report overview:

This report will be used to track concurrent DURs. The subsequent information will also be used to assist clients in managing Hard Rejects, Soft Rejects as well as Message Only edits. Reversals are also included in the report.

Detail Line Description:

Column Name	Description
Summary Page:	
Claims Summary:	
RxCLAIM Status	The claims status associated with the RxCLAIM transaction. For this reoprt, a claim Status can be any one of the following values: P = Paid Status, X = Reversal Status, R = Rejected Status.
Total Rxs	The total number of Rxs.
% of Total Rxs	The percentage of the total number of Rxs.

Total Plan Paid	The Client Total Amount Due.
Total Member Paid	The Client Total Patient Pay Amount. The patient pay would include copays and all other charges paid by the member.

DUR Information Summary:

DUR Type	DUR Reason for Service Code and Description
Clinical Level	DUR (Drug Utilization Review). Indicates how significant the first conflict is. This field reflects the significance that the originating database assigned to it. 0 = Not specified, 1 = Major, 2 = Moderate, 3 = Minor
Total DURs	
Count	Total count of DUR edits. An Rx claim may have more than 1 DUR edit.
% of All DURs	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types.
DURs on Paid Rxs	
Count	Total count of DUR edits on paid Rx claims. A paid Rx claim may have more than 1 DUR edit.
% of DUR Type	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types on Paid Rx claims.
DURs on Rejected Rxs	
Count	Total count of DUR edits on rejected Rx claims. A rejected Rx claim may have more than 1 DUR edit.
% of DUR Type	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types on Rejected Rx claims.
DURs on Reversed Rxs	
Count	Total count of DUR edits on reversed Rx claims. A reversed Rx claim may have more than 1 DUR edit.
% of DUR Type	The percentage is based on the total number of each unique DUR Type divided by the total number of all DUR Types on Reversed Rx claims.

DUR Tabs:

Rank	Ranking is based on total number of Rxs (Paid + Rjected + Reversal) in descending order. A gap in sequence may occur if two or more rows tie (known as Olympic ranking).
Top Drug-Drug Interaction (DD Only)	Drug combination with a DD DUR code
Top Drug	Product Name
Therapy / Reason	DUR Free Text Message
DUR Response	DUR Responses are categorized as: H = Hard Reject, S = Soft Reject, any other code = Message Only
Total Paid Rxs	The total number of paid Rxs.
Total Plan Paid	The Client total amount due.
Avg Plan Paid / Rx	The average plan cost per Rx.

Avg Member Paid / Rx	The average member cost per Rx.
Avg Days Supply / Rx	The average days supply per Rx.
Avg Quantity / Rx	The average quantity per Rx.
Total Rejected Rxs	The total number of rejected Rxs.
Total Reversed Rxs	The total number of reversed Rxs.
Total Reversed Amount	The total amount of reversed Rxs.

State of Nevada
Department of Health and Human Services
Division of Health Care Financing and Policy
Drug Use Review (DUR) Board

Medical Condition	Clopidogrel and morphine drug-drug interaction
Rationale	· Antiplatelet agents, such as the $P2Y_{12}$ receptor blocker clopidogrel, are used in the treatment and management of a variety of cardiovascular diagnosis including acute coronary syndromes (ST-elevation myocardial infarction [STEMI] and Non-STEMI/unstable angina), post percutaneous coronary intervention (PCI) and for patients with chronic stable angina, peripheral arterial disease , or stroke/transient ischemic attack (TIA) who are allergic to aspirin.[1] · Morphine, an opioid agonist, is used for the relief of pain, particularly moderate to severe acute pain (immediate-release) or chronic pain severe enough to require daily, around-the-clock treatment (extended-release)[2,3] · The "Can Rapid Risk Stratification of Unstable Angina Patients Suppress Adverse Outcomes with Early Implementation of the ACC/AHA Guidelines" (CRUSADE) initiative was a retrospective observational registry of patients with non-ST-elevation acute coronary syndrome that found patients treated with morphine (29.8%) had a higher adjusted risk of death than those not (odds ratio [OR]=1.48; 95% confidence interval [CI], 1.33 to 1.64).[4] · Because of this evidence of worse outcomes, morphine is now generally reserved for use only in patients with an unacceptable level of pain.[5,6] · The exact mechanism for the worse outcomes seen with morphine is not well understood, but morphine's effect on interfering with the antiplatelet agents that block the $P2Y_{12}$ receptor may be the cause.[5,6] · Current data suggests that carriers of the reduced function allele for Cytochrome P450-2C19 (CYP2C19) significantly modulate the effects of clopidogrel, thus reducing antiplatelet effects, leading to higher rates of cardiovascular events (particularly stent thrombosis and myocardial infarction around the time of PCI).[7,8] · In addition, two studies have implicated a drug-drug interaction between morphine and $P2Y_{12}$ receptor blockers as a reason for poorer outcomes. · A study involving 50 patients with STEMI undergoing primary PCI who were randomly assigned to either prasugrel or ticagrelor, morphine was an independent predictor of high residual platelet reactivity at two hours (OR=5.29; 95% CI, 1.44 to 19.49).[9] · A study involving 24 healthy subjects were given a loading dose of 600 mg clopidogrel and either 5 mg intravenous morphine or placebo. The morphine group had significantly delayed resorption of clopidogrel and a reduction in area under the curve for the active metabolite of clopidogrel by 52%.[10]
DUR Intervention	· Members who have ≥2 pharmacy claims for morphine and ≥2 concurrent morphine pharmacy claims for clopidogrel between November 1, 2014 and January 31, 2015.
Objective	· To assess the utilization or clopidogrel coadministered with morphine · To identify the percentage of members who have had a coronary event (MI, stroke, thrombosis, stroke, etc.) while taking clopidogrel and morphine compared to those who are taking clopidogrel without morphine. · To evaluate the impact of a retrospective drug utilization review (RDUR) initiative on antiplatelet and opioid prescribing habits.
Inclusion Criteria	· Members with ≥2 pharmacy claims for morphine and ≥2 pharmacy claims for clopidogrel concurrently between November 1, 2014 and January 31, 2015.
Exclusion	· Members with a primary payer other than Nevada Medicaid.

Medical Condition	Clopidogrel and morphine drug-drug interaction
Criteria	· Members without continuous plan eligibility in the last 120 days.
Intervention	· Each unique prescriber of patients meeting the above criteria will be notified through formal patient-specific letters sent via regular mail. All letters will include a brief introduction to the retrospective drug utilization review (RDUR) initiative, a summary of the literature as well as a summary of the patient's recent clopidogrel and morphine fill history, including prescriber information. Feedback forms will be included with the letter inquiring about the following: · Confirmation that the patient is currently under the care of the prescriber, and if not, does the prescriber have a record of the current primary care physician (PCP). · Confirmation that the patient is currently or was previously taking both clopidogrel and morphine · Confirmation that prescriber is aware of the new literature · Necessity for concurrent clopidogrel and morphine use. · This member or caregiver has been counseled regarding the potential drug-drug interaction between clopidogrel and morphine. · Future plan, if any to change therapy of clopidogrel or morphine. · Usefulness of RDUR information on a scale of 1 to 10.
Outcome Measure	**Possible outcome measures may include:** · Percentage of patients (with a new start of) clopidogrel who are also taking morphine · Percentage change in patients on clopidogrel and were taking morphine for at least ≥2 of three months at baseline and ≥2 of three months following intervention · Number of patients who switched clopidogrel · Number of patients who switched morphine · Number of patients who discontinued morphine · Percentage of prescribers who were unaware of the potential drug-drug interaction between clopidogrel and morphine. · Percentage of prescribers who plan on re-evaluating the patient's therapeutic regimen. · Prescriber rated usefulness of RDUR information on a scale of 1 to 10.
References	1. Mangla A, Gupta S. Antiplatelet Therapy. In: Crawford MH, editor. CURRENT Diagnosis & Treatment Cardiology. 4th edition. United States; McGraw-Hill Education; 2014. 2. Kadian® [package insert]. Morristown (NJ): Actavis LLC; 2012 Jul. 3. Morphine sulfate injection [package insert]. Deerfield (IL): Baxter Healthcare Corporation; 2003 Dec. 4. Meine TJ, Roe MT, Chen AY, Patel MR, Washam JB, Ohman EM, et al. Association of intravenous morphine use and outcomes in acute coronary syndromes: results from the CRUSADE Quality Improvement Initiative. Am Heart J. 2005 Jun;149(6):1043-9. 5. Breall JA, Aroesty JM, Simons M. Overview of the acute management of unstable angina and non-ST elevation myocardial infarction. In: Saperia GM (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2014 Oct [Cited 2014 Oct 31]. Available from http://www.utdol.com/utd/index.do. 6. Reeder GS, Kennedy HL, Rosenson RS. Overview of the acute management of ST elevation myocardial infarction. In: Saperia GM (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2014 Aug [Cited 2014 Oct 31]. Available from http://www.utdol.com/utd/index.do. 7. Mega JL Close SL, Wiviott SD, et al. Cytochrome P450 polymorphisms and

Medical Condition	Clopidogrel and morphine drug-drug interaction
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Appendix A

Interacting drugs to pull for review

Drug	GPI
Clopidogrel Bisulfate	85158020******
Morphine	65100055******

Appendix B

ICD-9 Codes for Coronary Events associated with clopidogrel use:

ICD-9 Code	Name
410	Acute myocardial infarction
411	Other acute and subacute forms of ischemic heart disease
413	Angina pectoris
434.91	CVA/Stroke
674 674.01 674.02 674.03 674.04	Any condition classifiable to 430-434, 436-437 occurring during… pregnancy childbirth the puerperium specified as
997.02	Postoperative cerebrovascular accident