BRIAN SANDOVAL
Governor

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NOTICE OF PUBLIC MEETING – DRUG USE REVIEW BOARD

AGENDA

Date of Posting:	**December 16, 2016**
Date of Meeting:	**Thursday, January 26, 2017 at 5:15 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**
Webinar Registration	**https://catamaranrx.webex.com/catamaranrx/onstage/g.php?MTID=e98a764fe0aecbb2f863b1c22e8871612** **Or go to www.webex.com and enter the Event Number listed below.** **Once you have registered for the meeting, you will receive an email message confirming your registration. This message will provide the information that you need to join the meeting.**
Event Number:	**747 701 145** **Click "Join Now"** **Follow the instructions that appear on your screen to join the audio portion of the meeting. Audio will be transmitted over the internet. No phone number is required.**

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 October 27, 2016.

b. Status Update by DHCFP: MSM Chapter 1200 changes

4. Board Actions

a. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for all prescription drugs for Hospice Program recipients.

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.

b. **For Possible Action:** Discussion and possible adoption of updated criteria for the Controlled Substance Pharmacy Lock-In program.

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.

5. Clinical Presentations

a. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for the medication class Incretin Mimetics.

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.

b. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for Lumacaftor-Ivacaftor (Orkambi®).

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.

c. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for Suboxone® (buprenorphine/naloxone), Subutex® (buprenorphine).

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. Detailed utilization of the top utilizers of opioids.

i. Discussion by the Board and review of utilization data.
ii. **For Possible Action**: Requests for further evaluation or proposed clinical criteria to be presented at a later date.

b. Utilization of agents used for the treatment of Opioid Induced Constipation

i. Discussion by the Board and review of utilization data.
ii. **For Possible Action**: Requests for further evaluation or proposed clinical criteria to be presented at a later date.

c. Gastroenterology studies in recipients with extended use of proton pump inhibitors.

i. Discussion by the Board and review of utilization data.
ii. **For Possible Action**: Requests for further evaluation or proposed clinical criteria to be presented at a later date.

d. Utilization of codeine containing cough suppressants.

i. Discussion by the Board and review of utilization data.
ii. **For Possible Action**: Requests for further evaluation or proposed clinical criteria to be presented at a later date.

8. Public Comment on any Standard DUR Report

9. Standard DUR Reports

a. Review of Prescribing/Program Trends.

i. Top 10 Therapeutic Classes for Q2 2016, Q3 2016 and Q4 2016(by Payment and by Claims).
ii. Top 50 Drugs of Q2 2016, Q3 2016 and Q4 2016 (by Payment and by Claims).

b. Concurrent Drug Utilization Review (ProDUR)

i. Review of Q2 2016, Q3 2016 and Q4 2016.
ii. Review of Top Encounters by Problem Type.

c. Retrospective Drug Utilization Review (RetroDUR)

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

9. 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.

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.

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If requested in writing, a copy of the meeting materials will be mailed to you. Requests and/or written comments may be sent to Ellen Felsing 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.

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STATE OF NEVADA

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MEDICAID
DRUG USE REVIEW BOARD
DRAFT MEETING MINUTES

Date of Meeting:	**Thursday, October 27, 2016 at 5:15 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**

Committee Members Present: James Marx, MD; Michael Owens, MD; Paul Oesterman, Pharm.D.; Jeffrey Zollinger, DO; Chris Shea, Pharm.D.

Committee Members Absent: David England, Pharm.D.

Others Present:

DHCFP: Shannon Sprout, Chief, Program Services; Mary Griffith, RN, Pharmacy Services Specialist; Darrell Faircloth, Deputy Attorney General

HPES: Beth Slamowitz, Pharm.D.

OptumRx: Carl Jeffery, Pharm.D.

Others: Coleen Lawrence, Moxy Health; Joe Schreck, Allergan; Dave West, United Therapeutics; Jin Nguyen, AZ; Kerry Kostman, AZ; Sandy Sierawski, Pfizer; Ann Nelson, Vertex; James Kotusky, Gilead; Sal Lofaso, Horizon; Elyse Monroy, Office of the Governor; Jeanette K Belz, NV Psychiatric Assn; Brian Evans, The Perkins Co; Kerry Bonilla, AZ; Gin Yun; AZ; Liz MacMenamin, RAN

Others On Line: Altamit Lewis, Amerigroup; James Riske, Wellpoint; Laura Hill, Abbvie; Saiza Elayda; Bruce Smith, GSK; Chris Stanfield, Supernus; Mark Schwartz, GSK; James Maloney, Optum

1. Call to Order and Roll Call

Paul Oesterman, Chairman: We will call the meeting to order. Please limit your presentation to 5 minutes. We will start by asking for public comment before we get into the agenda. If you do see the item on the agenda that you want to speak about, you can speak when we get there.

James Marx

Jeff Zollinger

Michael Owens

Paul Oesterman, Chairman

Darrell Faircloth

Beth Slamowitz

Shannon Sprout

Mary Griffith

Carl Jeffery

2. Public Comment on Any Matter on the Agenda

Paul Oesterman, Chairman: Do we have any public comment? Do we have anybody on-line?

Carl Jeffery: Yes, there are a few people.

3. Administrative

a. **For Possible Action:** Review and approve meeting minutes from July 28, 2016.

Paul Oesterman, Chairman: The first item is the review of the minutes from the July meeting. I have one question in regards to the final rule from CMS, where are we with that.

Mary Griffith: We are still in the process of working on them, we haven't hit the deadline yet. But we are working in getting the SPA submitted. CMS said we were one of the more efficient States they have worked with.

James Marx: I move for approval as submitted.

Michael Owens: Second.

Voting: Ayes across the board, the minutes are approved.

b. Status Update by DHCFP

Paul Oesterman, Chairman: Our next agenda item is the status update from DHCFP, in particular the Governor's Summit on Prescription Drug Abuse. A number of people in this room were fortunate enough to attend. Mary, I will let you give your update.

Mary Griffith: The Governor's Summit on Prescription Drug Abuse Prevention was held on August 31, and September 1. I was lucky enough to attend, Shannon and Beth also attended. Paul Oesterman and Dr. Marx also attended, we had representation from Medicaid and the Board. It was an excellent conference, I feel privileged just to attend. It included a multitude of stake holders including physicians, law enforcement, pharmacists, insurance companies and other State agencies, behavioral health agencies. It is going to take a collaborate effort for us to prevent any more prescription drug abuse or even to get a handle on it. This was encouraging because from my perspective, the first step to change is acknowledging there is a problem, and I think that is what we are doing with the Summit.

The next item was the prescription drug opioid abuse workshop that was held on October 20th. There are copies of the presentation in the back. A lot of the things were discussed, some of them were the CDC guidelines for prescribing opioids for chronic pain. Some of the other things discussed were the education of providers, drug testing policy criteria, determining the cause of pain before treatment with opioids. This is an on-going discussion that we will be continuing with our Board meetings for the foreseeable future and with more public workshops.

The other thing is Chapter 1200 changes that were approved in January and April are going to public hearing on November 8th. Those were revisions to the ADD/ADHD criteria, long-acting narcotic criteria, Suboxone revisions, Hep C agents. All these changes should go into effect on November 9th. That is all I have.

Shannon Sprout: This is Shannon Sprout, I'm the Chief over Policy Development and Program Management. In addition to what Mary provided, at the Summit there was a lot of information about the CDC guidelines, the statistics that are being taken nationally that I think are aligned really well when I went to the National Association for State Health Policy. There was again, the first full day was on the opioid crisis and what the states are doing. What we are really looking at is how we are going to move our policy to align with the movement that is occurring to make sure we are getting ahead of this crisis. So what you will see at the workshops that we will be holding is an effort to continue to have an open dialog with our providers and taking steps to make sure we are in line with those CDC Guidelines.

Paul Oesterman, Chairman: I think one of the big take-backs that I got from the Governor's Summit was we are all on the same page, we are all trying to accomplish the same thing. It doesn't do any good to point fingers, blaming

physicians or pharmacists or patients, we all need to work together and everybody appreciates the fact that it is a common goal. I am looking forward to tonight's discussion because I think we are going to be able to put some of our first steps into place. There are going to be some bumps in the road, but we have to do something. If we can impact one life, then we have done something very worthwhile.

James Marx: I would like to say that I came away with the same warm fuzzy feeling, but I didn't. There seems to be a lot of reliance with the CDC guidelines. There seems to be a lot of ignorance on this whole subject. It isn't because people know too much, it is because they know too much of the wrong thing. I think we have a big challenge amongst our prescribers. I was at a drug take-back this weekend and we had patients bring in medications left from a surgical procedure, but they get 100 Lortab and they only took two of them. This is far too common. And this is one thing they want to address, but mandating the seven-day rule is wrong, and I think we will get to that. There is a lot of misinformation. We have a big challenge to train our prescribers how to appropriately prescribe. We have to train the public as to behaviors and the proper mindset so there are some big challenges. It is not going to come from any set arbitrary guidelines.

c. Presentation of Annual Drug Utilization Review Report

Paul Oesterman, Chairman: We are going to have the Annual Drug Utilization Review Report. I will ask for public comment first. This is a report that is submitted annually and is due by September 30th. This report has already been submitted. Carl, do you want to run down the report?

Carl Jeffery: This is similar to the past years, a standard report. CMS seems to add a few new features every year. Mostly it is the same information. The first couple pages are demographic information. I will highlight a few things I think you may be interested in. Question 26, this was a new table, this is the top PA requests by PA drug name. I think it is a little more useful. I will let the Board continue to review it and let me know if you have questions. After question 42, the next page starts the summary of the Drug Use Review Board activities. That is what we provide to CMS that tells them what we have been doing all year. This is also the Federal Fiscal Year 2015, so it is the time when we did the special psychotropic meeting with the prescribers to create some new criteria. And the Executive Summary on the second to last page, not a whole lot to call out. Pretty standard information of what we go over every meeting. If there is something we should have submitted differently or something else, let me know. CMS will compile all these and make it available.

Paul Oesterman, Chairman: It looks like a very standard report. I didn't see anything out of the ordinary. We will need a motion to approve the report as submitted.

James Marx: On question 80, it asks about access to boarder states' PMP, we do have access to all the border states except California.

Mary Griffith: I don't think we do, do we?

James Marx: We have Arizona, we have Utah, but not California. The No is a qualification, they are in the PMP.

Jeff Zollinger: I am registered on the California PMP, but if you log into the Nevada PMP, you will get some of the other neighboring states except for California. So you have to register separately for California for their PMP. I have heard they are working on it, that California was going to work with our program. That would be nice to have that. The California PMP is very glitchy. It will go for a few months without problems, and then I can't get in when I have a patient there. It is not a good system. On 122, some of the MCOs in Nevada have some really stringent criteria for getting things approved, and it is very difficult. I think this is a good idea for MCOs to report their process, I think that is what they are asking there. Would that be available to us as the Board? What is the plan for that?

Mary Griffith: CMS is mandating that the MCOs have a DUR program. I'm not sure when the final rule will be in effect, but this is part of the requirement. They will have to have a DUR Board that is open to the public.

Jeff Zollinger: I have noticed that the MCOs will pick a third party reviewer, and they will switch back and forth. The one Amerigroup was using about a year ago was fairly straightforward, and then they switched and it became very difficult to get things approved. To me I get the feeling they chose the administrator based on who is going to deny the most. That is a big frustration.

Mary Griffith: Yeah, we hear a lot of complaints, we hear the fee for service is a lot easier to deal with.

Shannon Sprout: If there are concerns or issues, you should bring those to us so we can work with the MCOs.

Mary Griffith: If you can send some examples, we can look into that.

Jeff Zollinger: I can probably give you a list. It isn't just medications, it is also imaging, physical therapy and other therapies. I heard this complaint at a meeting a few years ago from another physician.

Mary Griffith: If you let me or Carl know, we can look into those issues, not just the pharmacy piece. One thing that is part of the CMS final rule with the DUR requirements, we are required to have a response to prior authorizations within 24 hours and we are required to have a 24 hour pharmacy call center, and the MCOs don't have the same requirement, but they will when the final rule goes into effect. I will give you my card and you can email me. At this point, that is all we can do.

Jeff Zollinger: When does that final rule go into effect?

Mary Griffith: I think it is 2017 some time. I don't have the specific date. But it is a CMS rule.

James Marx: I have an issue with the lock-in program. We have only had a few patients on lock in. But recently a patient had a prescription for methadone in addition to a short acting. The pharmacy where she is locked in refused to order it for the patient. I advised the patient to go to the emergency room when she went into withdrawal.

Mary Griffith: The lock-in program is not perfect, but the recipient can go to a different pharmacy.

James Marx: The problem is if a patient has been locked-in, when they go to another pharmacy to change, there is a stigma on the patient and they are reluctant to help. Pharmacists are already reluctant to fill prescriptions for these patients. It doesn't take much to make a pharmacy refuse these patients. It is frustrating and I think the lock-in program needs some criteria for the retail pharmacies. This is a bad situation when a patient goes into withdrawal because a pharmacist refuses to fill a prescription.

Shannon Sprout: We can put this on a future workshop.

Paul Oesterman, Chairman: Let's also put Lock-in on the next agenda to look at the criteria. In the mean-time, we need to approve the annual DUR report.

James Marx: I move to approve as submitted.

Chris Shea: Second.

Voting: Ayes across the board, the motion carries.

4. Clinical Presentations

a. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for medications used to treat Hepatitis C.

Paul Oesterman, Chairman: We have a couple clinical presentations, we are going to cover item 4 B first, the discussion and possible adoption of prior authorization criteria for medications used to treat Hepatitis C.

Do we have any public comment? Hearing none, we will go ahead with the presentation of the clinical information.

Carl Jeffery: This one is pretty easy. There is a new medication, Epclusa, a new pan-genotype medication. The AASLD guidelines are easy because there are no required combinations with ribavirin or previous treatments. On the proposed criteria in your binder, the recommendations right out of AASLD is added. It follows the genotype and if they have been treated with something else. It is a 12 week therapy.

Paul Oesterman, Chairman: The utilization data, the total number of hepatitis treatments has been fairly constant. A little drop in the Harvoni product as new products have been introduced.

Carl Jeffery: It has stabilized. I think when we first looked at these, there was some panic that these would go through the roof. We are not doing anything to regulate the number of prescriptions approved. I think the prescriber community is self-regulating and only treating those who really need treatment.

Paul Oesterman, Chairman: We need a motion to approve the updated prior authorization criteria for the medications used to treat hepatitis C.

Jeff Zollinger: I move to adopt the criteria.

Chris Shea: Second.

Voting: Ayes across the board, the motion carries.

b. **For Possible Action:** Discussion and possible adoption of prior authorization criteria and/or quantity limits for the medication class opioids and opioid agonists used for the treatment of pain.

Paul Oesterman, Chairman: Now we will go back to 4 A, the discussion and possible adoption of prior authorization criteria and/or quantity/prescription limits for the medication class opioids and opioids agonists used for the treatment of pain. Do we have anyone in the audience that wishes to address the Board? No comment.

As we started with this meeting, there have been a series of forums to address the concern with prescription opioid abuse and potential misuse. One of our mandates is to assist in the prevention of overdoses and fatalities that occur way too often, not just in Nevada, but the entire country. We started off with a basic guideline from the CDC for possible criteria that could be used. This is a guideline, a starting point, not an endpoint. We want to see some of the proposed suggestions to see what we can do to curtail addiction. Many patients start with acute pain and like the effects they get from the opioid and then become chronic users. That is what we want to look at, it will be a long process and we will not cure it overnight. I am involved with the DEA takeback programs in Northern Nevada. Someone is given a prescription for 120 oxycodone, they take two and then it sits in their medicine cabinet. Then a friend or family takes the remaining pills and it ends up on the street. What do we have for a starting point?

Carl Jeffery: We have some good utilization numbers to start. The first chart is the top 20 opioid utilizers. The top one is a methadone patient, 15,000 units, a lot of methadone. I think these are 10mg, since they took the 40s away from the retail pharmacies.

Paul Oesterman, Chairman: I calculate that as 41 tablets per day.

Carl Jeffery: I'm not so concerned with the top one, but a little down the list, you see the members with all the combinations. The one at the bottom of the first page is concerning. You have quite a few of these medications adding up. This brings to light what we need to focus on, the multiple medications and the large

quantities. The methadone patients will be a little unique if using them for drug withdrawal. I hope nobody is using for pain treatment.

James Marx: I use methadone in my patients, it is an excellent medication for pain, and have used it for over 20 years. They need to get it through a treatment center if using for withdrawal.

Carl Jeffery: The next report is the top opioids trending graph. The hydrocodone and acetaminophen combination is by far the top, followed by the oxycodone and acetaminophen. Then it works its way down. Embeda is now preferred as an abuse deterrent.

James Marx: Are these individual claims?

Carl Jeffery: Yes.

James Marx: So this is an aggregate?

Paul Oesterman, Chairman: Those are individual patients.

James Marx: Are those total milligrams?

Carl Jeffery: Those are number of tablets.

James Marx: 15,000 tablets? That's not possible.

Carl Jeffery: Yes.

James Marx: I want to see that claim.

Carl Jeffery: It is over a year time.

James Marx: Oh, ok, I can see that maybe in a year, that's still a lot. That is over a 1000 month. I would still want to see that.

Carl Jeffery: We can try to get some consolidated case studies so we can look at patients like this. We need to be careful of PHI.

[Inaudible side conversation]

Paul Oesterman, Chairman: The concern is the patient getting 15,000 tablets per month, then the next is patients getting four or more opiates per year. Do they get them at the same time or transition from one to another? For me, the third patient down, they got a 120 of one item and then 240 of another, that is probably a couple fills. But a little further down, they have seven different opiates, there are some smaller quantities and some with really big quantities.

Beth Slamowitz: When you look at some of these patients with multiple products, are they seeing multiple types of prescribers, like ERs to primary care to a pain specialist?

James Marx: The other issue is the strength of the tablet, there is no way to know the total dose.

Jeff Zollinger: I think that would be interesting to see if these are getting paid together.

Paul Oesterman, Chairman: I would like to see on these 20 patients to look at the calendar for what they are getting and when.

Shannon Sprout: As we are pulling the data, we are also doing the work on the back end to identify trends and issues that we need to look at. We are doing that now, and we will present that to you.

James Marx: I think it would also be helpful to have diagnosis codes and hospitalizations or ER utilization.

Beth Slamowitz: We just did a presentation for ER visits and how their medications tied into the visits. Some of the data is very hard to drill down, especially when it comes to diagnosis. You are seeing why they came to the ER, not why they are getting a pain medication. You can't tell truly what the diagnosis is, I just want to give that disclaimer before we run the data. If that is what you are looking for, that might be data that is hard to come by. But we can see if these 20 recipients went to the ER or were hospitalized.

Paul Oesterman, Chairman: It might also be valuable to add in concurrent benzodiazepine use. This is an open forum, if anybody in the audience has anything to share, please step forward.

Coleen Lawrence: My name is Coleen Lawrence with Moxie Health Policy. I would offer a suggestion on that data, I was not sure if it was point of sale or physician administered data. The delivery model would be a clarification that you might want to look at. If it was being administered in the emergency room or a doctor's office vs. a retail setting. And then the type of specialty of the provider that is providing the medication. That might help you narrow the buckets.

Chris Shea: That is helpful, because we have had patients discharged on a list of medications to rehab. When they are admitted to the hospital, and they are discharged on the same medications, then the admitting prescriber to the rehab facility needs to figure out where these medications are coming from. It does help to know where these prescriptions are coming from so we know what to look at.

Coleen Lawrence: That will help on the education side.

Carl Jeffery: These are all point of sale claims, there are not any physician administered drug claims.

Coleen Lawrence: Then you have another whole set of medications being given in a clinic setting that would need to be addressed.

Kerry Bonilla: I am Kerry Bonilla with Astra-Zeneca. The data set is a challenge when I talk to providers in every group. We have a lot of data, if there could be some communication back to the ERs. Some of these patients may only see ERs. The primary diagnosis is important to see on these patients. Maybe part of the whole dialog, the ER physicians could make sure they are coding properly.

Jeff Zollinger: I would add, looking at these patients here, I hope they are not being prescribed by the ER physician. I don't think they should be prescribing any long-acting agents.

Beth Slamowitz: I can tell you from my experience, at UMC outpatient, the outpatient pharmacy at the clinic, the majority of the prescriptions came from the ER. The majority of those were for pain medications until a pain protocol was put in place. We did get prescriptions for long-acting agents. That is because the patient comes in for a refill of their routine pain medications.

Jeff Zollinger: Then you are just reinforcing bad behavior at that point.

Beth Slamowitz: I agree, that is why we are here now. Protocols to limit days supply have helped.

James Marx: We used to have patients take their medications with them to the hospital, but they don't get them back on discharge. It is a real problem.

Beth Slamowitz: We would keep them in the pharmacy, locked in a cabinet until discharge. Then the nurse or patient needs to come get them when they are discharged. Meds were destroyed if they didn't get them.

James Marx: I think there should be a better system to get the medications back.

Beth Slamowitz: That is good in theory, but with a hospital the size of UMC, that can't happen.

Paul Oesterman, Chairman: In my hospital it is the case manager that reminds the patient to get the medications. I had two bags of meds to destroy because the patient passed away. So it doesn't seem to be a problem.

James Marx: We tell our patients not to take their medications to the hospital. Another issue is if the patient gets too much opioid, but that is not common with my patients. I think we need to do a better job.

Beth Slamowitz: I think our concern here is that we need to look at a starting point, and looking at the outpatient now. The criteria we have is similar to what some of the other states are looking at.

James Marx: The inpatient side does roll down to the outpatient.

Beth Slamowitz: That is something we can take away to address at a later time.

Paul Oesterman, Chairman: Looking at the top 20 opiates by claim count. The combination hydrocodone is number one, looking at the numbers, there are a lot of people that are in pain, but the average claim ran between 63 to 109 tablets per prescription. I understand patients with chronic pain, but to get an average that high, there are a lot of patients probably getting more than they need.

James Marx: You have to look at it from the other side. The quantity limits one or two pills per day, this leads to higher strengths on the street. I like my patients to take more tablets that are lower doses. I think we need to rethink the quantity limits. You have to think of the total dose per day rather than number of pills.

Paul Oesterman, Chairman: I understand that, but what we are doing now is not working, and we need a starting point for something to help. Other states have tried these, but we need to do something.

James Marx: Do you want a bunch of 30mg morphine tablets or 100mg tabs on the street?

Paul Oesterman, Chairman: I don't want either of them on the street.

Shannon Sprout: When we look at the national research, states are moving to a supply limit, a 3 or 7 day supply. This is the first proposal and round for you to review. But that is where the national trend it moving and they have had some success.

James Marx: Are these based on CDC guidelines?

Beth Slamowitz: The CDC recommends no more than a 3 day supply for an acute episode. If more is needed then they should require PA.

James Marx: Would surgery be a reason?

Beth Slamowitz: Yes, and that is an exception on the criteria. The states have gone to some middle ground so some are doing a 7 day supply. This helps limit the number of pills patients can get if they are doctor shopping.

James Marx: The PMP should stop the doctor shopping.

Beth Slamowitz: Yes, and this was addressed at the summit, but there is no penalty for not looking at the PMP, it is encouraged, but not mandated.

Jeff Zollinger: I think it does say there is a disciplinary action, maybe even something criminal on the original. It scared a lot of doctors. It said the doctors could be committing a crime.

Beth Slamowitz: It leaves it to the Boards to decide the disciplinary action.

Paul Oesterman, Chairman: I'm looking at the proposed criteria, I think I would like to add one more potential exception, and that is if the patient has been seen or is prescribed in consultation with a pain specialist.

James Marx: That is pretty impossible, there are not enough pain specialists.

Paul Oesterman, Chairman: That would be an exception.

James Marx: I know this would help me, but in a bigger picture, most pain management is done by primary care doctors.

Mary Griffith: I don't think that is the case here. In a recent report, we looked at all the narcotics, the vast majority are coming from one pain specialist office, and they were all in the top five. The data that I have seen did not back that up. It was not the primary care doctors.

Michael Owens: From a personal practice, it takes 3-4 months to get someone into a pain specialist. I know that is the same way for all the prescribers in our clinic. It is a distraction in our practice. It does seem there is a shortage of pain specialists.

Paul Oesterman, Chairman: I want to go back to the proposed criteria, and especially the people in the audience, we know this is just a starting point, if the initial prescription is for 7 days or less, it would not require a prior authorization.

Patients that have had a prescription within the last 45 days would be exempt, so we are trying to start from the beginning with new patients. I think it is a small number of patients we are looking at initially. It will prevent them from getting into trouble down the road.

James Marx: Will that impact the call center?

Beth Slamowitz: As long as the prescription is for 7 days or less, then they do not need a PA.

James Marx: But what happens after 7 days?

Beth Slamowitz: They get another 7 days.

Carl Jeffery: They can get that up to 13 times.

James Marx: Who is going to paying for all those office visits? The patient is going to have to be coming back.

Carl Jeffery: The intent is to catch those for acute pain. They get 7 days' worth and then they are done. We don't want dentists writing for 30 days of Percocet.

Shannon Sprout: The goal is for individuals with an acute issue. A 7-day supply is sufficient. We want to get away from the larger quantities that may start a pattern with someone. If you meet with a patient that needs more than 7 days, then you would initiate a PA. But we want to stop the 30-days supply when a 7 day supply would be just fine.

James Marx: I guess my issue is that we should have prescribers that are educated, if someone tears their ACL, they will have pain for more than 7 days, and now they need a prior authorization. I think there is going to be a much larger unintended consequences of a lot more work on the prescribers.

Shannon Sprout: That is why we are trying to step this up slowly so that we can look at the outcomes. If we do everything at once, we can't tell what is working or not. We have had a workshop on this.

Jeff Zollinger: I think this is a good idea and I would support this, as long as you are prepared for a greater administrative burden. I think if we are prepared for that, then I support this.

Carl Jeffery: If we can be the scapegoat, prescribers can blame Medicaid and relieve the physicians from that pressure, I think that would help.

Jeff Zollinger: I think it would. I have heard other physicians tell patients that based on what the insurance will cover. Many insurance companies only covers a small amount, and the patients are generally ok with that. So I think it might help. It lessens the conflict with the patients.

Michael Owens: Our clinic has adopted the CDC guidelines, we are not taking any new opioid patients. We have a monthly morphine equivalent max. That is the only way I could prescribe. I have a hard time telling patients no, but this gives me a good background to deny some patients.

James Marx: So you are not taking any new patients?

Michael Owens: Right, I am not a pain specialist, I'm sure they may have pain, but to put me in the position to write for medication I am not comfortable with, that is not what I signed up for. I don't have the control over the situation that I would like.

James Marx: 40% of encounters in the primary care environment is for pain, so it seems you would be excluding many patients that could be helped. I can see if they are on high doses, those patients probably need to be in pain management. I did have an opioid naïve patient, I wanted 2.5 mg Percocet, and we could not find it or the pharmacy could not get it. This is a problem that we can't get the lower doses.

Chris Shea: I think it boils down to an economic issue, a supply and demand. No one uses the 2.5 mg. You could have used a half of a 5mg tab.

James Marx: That is what we ended up doing, but for the elderly, it isn't a good solution. That is where we need to start working.

Jeff Zollinger: I think what we are trying to do is to prevent these patients from getting hypersensitive on these high doses. That way we don't have the patients going back to primary care getting their doses escalated. I see this frequently, a patient gets injured, they can't get in to an orthopedic on time, doses get escalated, and by the time they are in the pain clinic, they are on an extremely high dose. Hopefully this new proposal will mitigate some if these issues.

Paul Oesterman, Chairman: Right, this is a starting point, there will be some amendments and some changes in the future. Do we have a motion to approve?

Michael Owens: Is this for 7 days per month?

Carl Jeffery: It could be consecutive 7-day fills, they could go through their 13 fills right away.

James Marx: If you are going to limit to 7 days, then you should limit the dosage. Otherwise, it will create a pull for the 2.5mg tablets. If you will give them 7 days of 10mg Percocet, then it is missing the purpose.

Carl Jeffery: I think that is a great idea, throw out some numbers, in a 7 day period, how many morphine equivalents should be allowed for an acute treatment.

James Marx: I think you need to look at a daily basis. There should be some establishment of an opioid naïve patient. If you want to create an addict, give them something they like.

Carl Jeffery: We can put a quantity limit, it would be done at the product level per seven days. But what we have coming in early 2017 some software that will calculate the morphine equivalent dose, but for now it would be a large manual effort.

Jeff Zollinger: I think if you want a number, the CDC has a dose limit.

James Marx: The CDC guidelines are all level 2 and 3 evidence, there really wasn't any good evidence. It is poor evidence they are based on.

Jeff Zollinger: But it is the only evidence we have right now. They looked at one study of patients having a poor outcome when they exceed certain doses. When we are looking for a number, let's say 100mg morphine equivalent per day.

Beth Slamowitz: We are setting a max, the prescriber can still prescribe anything under that limit. If we start with baby steps.

James Marx: But if we start with something too high, then we are not going to be doing any good.

Shannon Sprout: I would ask then, would it be appropriate that we may need some additional information to come back with those limits at the next meeting?

James Marx: I think we can get something out of this.

Paul Oesterman, Chairman: What if we add no more than 100mg morphine equivalence per day.

Jeff Zollinger: I would say 120mg per day.

James Marx: If we are going to make this a usable guideline, I think 20mg morphine per day is good for an opioid naïve patient.

Darrell Faircloth: Will the experienced opioid user be getting a prior authorization?

Jeff Zollinger: What about a patient not opioid naïve who hasn't filled anything in 45 days, and then has surgery?

Beth Slamowitz: The exception criteria would allow that since they are having surgery. We can add 120mg within 24 hour period. How do we figure out who is opioid naïve?

Carl Jeffery: It is always easier to come down. From the claims side, we can't always know who is opioid naïve vs opioid experienced. What we are talking about here is putting in the system as limits, anything that exceeds the max we establish will require a PA.

Paul Oesterman, Chairman: This is just a starting point, we can create some framework and go from there. We have some public comment.

Elyse Monroy: I am Elyse Monroy and I am the Health and Human Service Policy Analyst in the Governor's office and I have been working on these issues. I want to throw something out, something that really resonated with me and a few others, during the Governor's planning meeting, one of the individuals that gave his personal story that they wish someone would have just told me of the risks of opioids. He had a fall that started opioids for pain and spiralled to heroin. Other states encourage patient consultation.

Paul Oesterman, Chairman: Patient consultation is required by a pharmacist.

Elyse Monroy: But not by a prescriber. If I was told how an opioid works and the risks, I think I would ask for something else, I don't think I am the only one. If there is a place for consultation, I think that would help.

Paul Oesterman, Chairman: One thing that resonates and keeps coming up is education.

??: I cover Oregon, I cover all the managed Medicaid, and they are starting to ask the patients if they are opioid naïve. My dad had a knee replacement last week, he had a 120 Percocet, he took 8, now on ibuprofen and now we have all these Percocet in his medicine cabinet. Patients have been trained with antibiotics to finish therapy, that is the biggest drug that patients take. Now you prescribe something for PRN use, they don't always know how to take it.

Carl Jeffery: Maybe we add under number 2, patient has been educated about the risks and the benefits of an opioid.

James Marx: Where is that supposed to take place?

Beth Slamowitz: It wouldn't be anything more than an attestation. I don't know that that does anything.

Chris Shea: If you look at the discharge summaries from the hospitals, it says the PMP was checked, the patient was educated and we told them to stop smoking.

James Marx: There are 10 times as many die of smoking related illness than opioids.

Beth Slamowitz: We need to look at the criteria we have here.

James Marx: Why don't we create a patient education sheet that needs to be given with every opioid prescription?

Shannon Sprout: We have to look at what we can do within Medicaid and what the DUR Board can do. The education for patients is something we can take back. For the purpose of this, we will take the education material and go to public and behavior health and come with a collaborative effort across the Division. You have the option to do that in your clinic now.

James Marx: We have the opportunity to educate the patient at the pharmacy. If they want the prescription, then they have to listen to the pharmacist.

Chris Shea: That needs to come from the Legislature. The patient has the ability to deny counseling. What is being proposed is beyond the ability of the DUR Board.

Carl Jeffery: Are med guides required for opioids?

Chris Shea: No, but even with those, we have to hand them to the patient, but they still have the right to refuse counseling. We have to document it.

Paul Oesterman, Chairman: You can't force a patient to listen to your counseling. We have the proposed criteria, we added a couple points, Carl do you have those points?

Carl Jeffery: Yes, we added the morphine equivalent doses, not to exceed 120mg per day.

Paul Oesterman, Chairman: And we are going to add education.

James Marx: I thought we were going to use a smaller dose.

Carl Jeffery: This is for the seven day limit, looking at 120mg limit, anything exceeding that. If you set it at 20, you're going to trigger a lot of PAs.

Chris Shea: Isn't that something that if we put 120 in now, then we could review that in the future and lower the ceiling if appropriate.

Paul Oesterman, Chairman: Do we want to lower it to 100?

James Marx: I want to lower it to 40mg.

Michael Owens: Don't they get 30 days after discharge for requiring prior authorization?

Carl Jeffery: That only applies to psychotropics.

James Marx: For non-post-operative pain, 100mg is way too much.

Shannon Sprout: Would you prefer the data at the next Board meeting and create the limit then? Then just make the decision on this proposed criteria today, and review again at the next Board meeting.

James Marx: Let's set the limit low and see how many object to it. Let's set it at 40, and then we are guiding behavior. If we set it at 100 or 110, then people will think that is appropriate for non-surgical pain.

Jeff Zollinger: What would be a typical prescription for an acute injury?

Michael Owens: Let's say someone comes with a sprained ankle, can barely walk, we wrap it and give them crutches. The most I am willing to do now is for a short prescription is four or six 10mg tabs per day.

James Marx: I would give them a shot of Toradol and 800mg of ibuprofen.

Michael Owens: But he was asking about opioids, the usual dose would be about four to six tablets per day.

Jeff Zollinger: That is my suspicion, it will create a huge administrative burden for triggering prior authorizations.

James Marx: We need step therapy, the question should be has the patient been on a non-steroidal at the max dose. If we are not going to do that, then we are perpetuating the problem.

Beth Slamowitz: That is already in there. Should we read the criteria?

James Marx: They may consider it, but they don't do it.

Paul Oesterman, Chairman: I think we are trying to come up with our morphine equivalent max. I would propose we consider 60 as splitting the difference and come back next time with data with the doses that are prescribed.

James Marx: I'll settle for 50mg.

Paul Oesterman, Chairman: Ok, 50mg morphine equivalents? Any other comment?

Jeff Zollinger: I think the lower the better, but there are a lot of people that prescribe more than that. You have already gone lower than what Dr. Owens says he would prescribe. The other thing is maybe for another day is long-acting agents.

Paul Oesterman, Chairman: So are we at 55 or 60?

Chris Shea: 60 would be easier to prescribe.

Paul Oesterman, Chairman: We have the criteria with the education piece and no more than 60 mg morphine equivalents per day. There is always an opportunity for a prior authorization to exceed. We need a motion.

Jeff Zollinger: I motion to approve as presented.

Michael Owens: Second.

Voting: Ayes across the board, the motion carries.

James Marx: If we are not getting a lot of objection to the 60mg, I think we should ratchet it down.

Paul Oesterman, Chairman: I agree, for the next meeting, can we have the data be brought back. When will this be implemented?

Mary Griffith: It has to go to public hearing, so probably about 6 months.

Paul Oesterman, Chairman: So not for the next meeting, but it would be interesting to see what medications that come out of the emergency room.

Carl Jeffery: I will try to tease it out, but it would be interesting to see the details of first-time fills.

Chris Shea: And then can you break it down by prescriber type?

Carl Jeffery: We can try, but sometimes, the specialties are not accurate in our system.

5. Public Comment on any DUR Board Requested Report

Paul Oesterman, Chairman: We will move along on the agenda, next is the Board Requested Reports. Do we have any public comment?

6. DUR Board Requested Reports

PO: The first one is utilization of agents used for the treatment of Opioid Induced Constipation.

Carl Jeffery: This is a follow up request. The criteria has not been implemented yet, so we won't see any shift in utilization yet. There is a break out of the different products.

Paul Oesterman, Chairman: I think it is interesting to see the increase in Movantic and maybe is related to the tv advertising. Are you aware of any head-to-head studies with Amitiza and Movantic?

Carl Jeffery: I'm not aware of any.

Paul Oesterman, Chairman: When will this criteria be implemented?

Carl Jeffery: November 9, 2016.

Paul Oesterman, Chairman: Maybe we can bring it back then.

James Marx: There is an oral product coming out and it should be available soon.

Paul Oesterman, Chairman: The next on the agenda is the non-opioid pain medication utilization. One of the things we were looking for is if there were any increase in utilization when hydrocodone went CII.

Carl Jeffery: I don't see an increase.

Paul Oesterman, Chairman: I have a question, Humira and Enbrel?

Carl Jeffery: I saw that and left them in there, they are technically non-opioids for pain like rheumatoid arthritis. And I thought it was interesting their quantities still fall in the top 20.

Paul Oesterman, Chairman: Pretty consistent.

Carl Jeffery: We will have to monitor after the opioid change.

Paul Oesterman, Chairman: After implementation, we will have to bring this back. The next report is the one we struggle with is the correlation of emergency room visits for asthma and COPD and current treatments.

Carl Jeffery: We took all the members with a diagnosis of asthma or COPD in an ER visit and then pulled what medications they are on. We have a chart that breaks down all the people that had a diagnosis on an ER visits, almost 5,000 people, when we get to the number of people on a steroid, we are about 1,000 patients. That means we have about 4,000 members who were admitted to the ER for asthma or COPD and not on a steroid inhaler. I think there is a big opportunity for education. We could look at a retro-DUR. We could look for recent ER admissions, check their profile and then send a letter to the prescriber alerting them their patient is not on adequate therapy.

Paul Oesterman, Chairman: The next report is the diagnosis of esophageal cancer and proton pump inhibitor utilization.

Carl Jeffery: This didn't show anything like I thought it might. The first chart is the number of members with a cancer diagnosis, about 92.

James Marx: Is there any overlap that have more than one diagnosis?

Carl Jeffery: Could be, I didn't compare. But then you look at their medications, and not many are on a PPI. There are only 8 patients that are on some kind of GI medication.

Chris Shea: Why were we looking at that?

Paul Oesterman, Chairman: I think we were looking for a cause and effect.

Carl Jeffery: I think you would need to do a lot more data mining to make this more useful. We would need to take these 92 patients and really dig into their medications for the last 10 years and other risk factors. We wouldn't have information on that.

Paul Oesterman, Chairman: The next chart is all the GI related medication utilization, I found this interesting. We have a number of proton pump inhibitors and H2 receptor antagonists. Ranitidine shows up twice, once at the top and then about half-way down.

Carl Jeffery: That is the over the counter. This is every fee for service patient that has been on any kind of GI related medication. About a year ago we put a limit so they can't be on a PPI and H2 concurrently. I thought we were going to get a lot of pushback, but we really don't hear too many complaints.

Paul Oesterman, Chairman: Maybe more of a question for the P&T, is there any advantage for preferred products in this category.

Carl Jeffery: Yes, they are an included class and Nexium and pantoprazole are the preferred medications.

Paul Oesterman, Chairman: There is a lot of famotidine and ranitidine.

Carl Jeffery: What we can do on the P&T side is force the use of the generic.

Paul Oesterman, Chairman: If you look at the sum of the paid amount, the Nexium, is there a contract, it seems like that is a lot, but I'm not sure that is the final cost.

Carl Jeffery: That isn't the true cost.

Paul Oesterman, Chairman: Is it possible to do a follow up for those patients on PPI that have been on it for an extended period of time to see if they have had an endoscopy or GI consult.

Carl Jeffery: For those types of requests we have to work with the medical claims vendor. We can try it.

Paul Oesterman, Chairman: Cough suppressants with dextromethorphan or guaifenesin.

Carl Jeffery: The first graph shows all the cough suppressants total, I thought it was interesting. I don't ever really think of it, but benzonate is the largest use. Promethazine has the quantity limits now.

James Marx: How much did the utilization change with that quantity limit.

Carl Jeffery: We looked at that at one of the other meetings, and there was a pretty good reduction. The use looks to be seasonal, the fall and winter shows an increase. Liquid combinations are next, most of these are pretty reasonable.

Paul Oesterman, Chairman: When I tried to review the top 20 cough suppressant with the liquids, the guaifenesin with codeine has about four different entries, it doesn't look like they are reflected in the liquid combination, only the Iophen C is there. I think for the most part, most practitioners, the guaifenesin with codeine is the go-to cough syrup.

Carl Jeffery: I think it is because of the way they are listed in our system, the combinations with codeine fall in the codeine class.

Paul Oesterman, Chairman: Can you bring this back next time with the codeine?

Carl Jeffery: Sure, the request for this report was combinations of dextromethorphan and guaifenesin. We can look at that next time.

Paul Oesterman, Chairman: I know why we looked at the promethazine before, we might want to consider quantity limits on the codeine products for next time.

7. Public Comment on any Standard DUR Report

Paul Oesterman, Chairman: Now we have the DUR Standard Reports. Any public comments?

8. Standard DUR Reports

Carl Jeffery: These are the regular charts with the Q3 added. Factor products and antipsychotics are always fighting for number one for amount paid. Hydrocodone always takes number one in the count of claims. We called out the hepatitis treatments, but it is holding steady or maybe even dropping a little. Same with the top 50 drugs. Everything is holding steady and not out of the ordinary.

Paul Oesterman, Chairman: I am seeing a good pattern for the average day supply, generally less than 30 day supply, I'm assuming patients are being started on a shorter day supply.

Carl Jeffery: You're looking at the Lisinopril and atorvastatin. I wouldn't guess it is a starting dose, but rather the nursing home pharmacies doing a short fill. They're not supposed to be doing it that way.

James Marx: On the second quarter, there were 129 claims for naloxone for $313,000, is this over $2000 per claim?

Paul Oesterman, Chairman: Have there been any issues with Epipens?

Carl Jeffery: As far as supply? Not that I am aware of. I heard Auvi-Q is coming back and there is another manufacture that is trying to come out too. I'm sure there will be some class-action activity coming down the road.

Paul Oesterman, Chairman: Our retro-DUR.

Carl Jeffery: I don't have anything to report this time, but I'm always looking for ideas. I think we have one with the asthma and we will get that one rolling. The Pro-DUR is more of the same.

9. Closing Discussion

Paul Oesterman, Chairman: Closing discussion. Any public comment? Date and location?

Carl Jeffery: January 26, 2017 probably right back here.

Paul Oesterman, Chairman: Meeting adjourned at 7:40PM.

Criteria for Nevada Medicaid

Hospice Medication Coverage PA

Executive Summary

Purpose: Promote prudent coverage for recipients enrolled in Hospice

Setting and Population: All members enrolled in Hospice

Targeted Products

All Medications not covered by Hospice

Approval Duration

- Prior authorization will be for 3 months

Approval Criteria

Prior Authorization Criteria:

Prior Authorization will be given if all of the following criteria are met:

A. The prescriber has verified the recipient is enrolled in a hospice program.

B. The requested medication is not being used to treat symptoms of the terminal hospice diagnosis.

C. The requested medication is medically necessary to treat the recipient

D. The requested medication is not providing a curative or long-term prophylactic therapy.

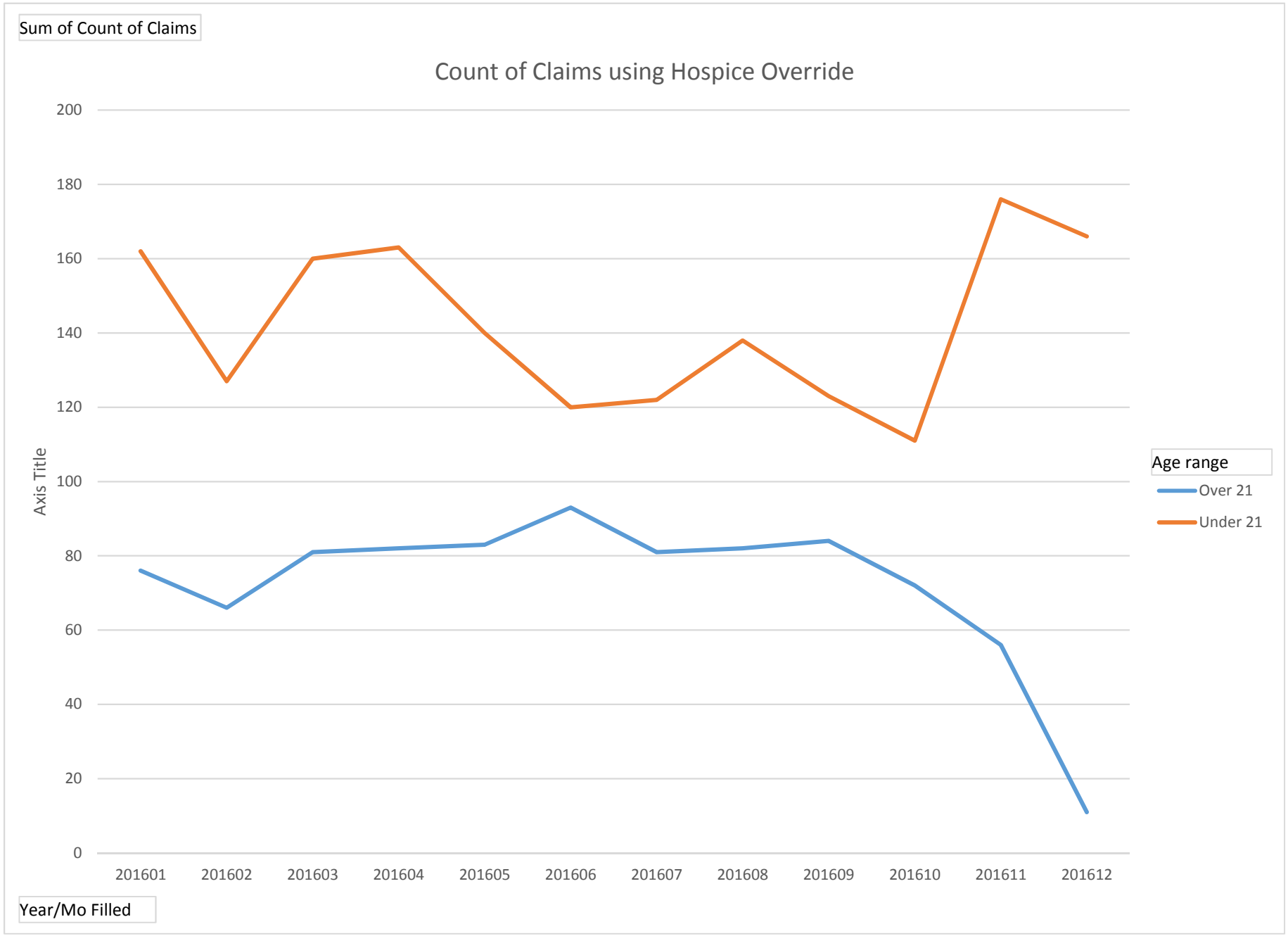
Quantity Limits

N/A

Hospice Override (Top 20)

1/1/2016 - 12/31/2016

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Pharm Paid
Under 21	**829**	**947**	**$380,939.18**
RANITIDINE HCL	124	138	$1,919.35
E.E.S. GRANULES	33	68	$18,579.23
BUDESONIDE	55	57	$16,728.45
CETIRIZINE HCL ALLERGY CH	53	56	$838.28
STERILE WATER IRRIGATION	39	50	$2,340.50
BACLOFEN	44	49	$1,478.46
PREDNISOLONE	44	47	$634.49
TOBRAMYCIN	45	45	$155,499.01
PULMOZYME	43	44	$160,346.97
MONTELUKAST SODIUM	44	44	$3,856.26
LEVETIRACETAM	38	40	$1,227.78
FLORANEX	37	39	$1,622.98
CEPHALEXIN	26	38	$745.73
SULFAMETHOXAZOLE/TRIMETHO	36	38	$1,270.18
POLYVITAMIN/IRON	37	37	$492.15
FERROUS SULFATE	32	34	$526.38
GLYCOPYRROLATE	32	33	$2,720.75
CETIRIZINE HCL	30	32	$441.82
NEXIUM	29	30	$7,723.28
INFUVITE	8	28	$1,947.13
Over 21	**267**	**440**	**$7,364.29**
FUROSEMIDE	17	49	$365.69
MORPHINE SULFATE ER	11	31	$684.93
SIMVASTATIN	21	29	$316.61
QUETIAPINE FUMARATE	13	26	$349.67
GABAPENTIN	19	23	$378.91
LAMOTRIGINE	11	23	$283.61
VITAMIN D	9	21	$92.43
JANTOVEN	4	19	$126.75
LISINOPRIL	18	19	$207.77
AMLODIPINE BESYLATE	18	19	$209.47
FOLIC ACID	14	16	$87.06
PROPRANOLOL HCL	7	16	$173.86
LEVOTHYROXINE SODIUM	15	16	$366.02
TOPIRAMATE	11	14	$174.78
METFORMIN HCL	12	14	$155.35
MEMANTINE HCL	6	13	$194.31
ROPINIROLE HCL	10	13	$174.81
SENSIPAR	4	12	$2,145.78
METOPROLOL TARTRATE	5	12	$119.13
LEVETIRACETAM	9	11	$234.82
HYDROXYZINE HCL	10	11	$163.90
RANITIDINE HCL	7	11	$133.13
SPIRONOLACTONE	11	11	$146.66
TEMAZEPAM	5	11	$78.84
Grand Total	**1096**	**1387**	**$388,303.47**


Sum of Count of Claims
Count of Claims using Hospice Override
200
180
160
140
120
100
80
60
40
20
0
Axis Title
201601
201602
201603
201604
201605
201606
201607
201608
201609
201610
201611
201612
Age range
Over 21
Under 21
Year/Mo Filled

GGG. Medications for Recipients on Hospice

Last Reviewed by the DUR Board: January 28, 2016

Medications for recipients on hospice are subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the Social Security Act (SSA) 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

Medications for recipients on hospice can be covered by Nevada Medicaid if determined to be not related to the terminal hospice diagnosis. All medications for recipients who are over the age of 20, and enrolled in the hospice program will require prior authorization approval. Approval will be given if all the following criteria are met and documented:

a. The recipient is over the age of 20; and

b. The prescriber has verified the recipient is enrolled in the hospice program; and

c. The requested medication is not being used to treat or manage symptoms of the terminal hospice diagnosis; and

d. The requested medication is not being used for palliative care but is medically necessary to treat the recipient; and

e. The requested medication is not providing a curative or long-term prophylactic therapy.

2. Prior Authorization Guidelines

a. Prior Authorization approval will be for three months.

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

Lock-In Savings Report December 2016

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 December 2016	Total Amount December 2016	Total Savings December 2016
	747	9,101	$670,099.16	5,846	$595,484.65	$ 74,614.51

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 December 2016	Total Amount December 2016	Total Savings December 2016
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	10	1545.13	-1458.33
4	2/1/2009	3/1/2009	10/26/2009	I	9	184.93			
5	2/1/2009	3/1/2009	12/31/2039	A	0	0			0
6	2/1/2009	3/1/2009	12/31/2016	I	26	731.87	14	177.18	
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	10	4642.07	-3935.7
13	8/16/2009	9/16/2009	11/30/2015	I	1	11.3699			
14	8/25/2009	9/25/2009	11/12/2015	I	8	970.5			
15	10/1/2009	11/1/2009	12/31/2039	A	4	9.3			9.3
16	12/1/2009	1/1/2010	9/13/2016	I	6	401.17			
17	12/1/2009	1/1/2010	7/31/2016	I	0	0			
18	4/11/2010	5/11/2010	12/31/2039	A	9	453.07	14	239.41	213.66
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	1	19.66	177.33
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	17	1856.56	812.88
23	10/1/2010	11/1/2010	12/31/2039	A	6	681.86	6	134.18	547.68
24	10/1/2010	11/1/2010	12/31/2039	A	15	2089.34			2089.34
25	1/1/2011	2/1/2011	9/25/2012	I	27	3042.05			

educational efforts will be directed to help providers improve their efficiency in the allocation of the finite resources available for Medicaid clients.

d. Eligibility

Please refer to MSM Chapter 100 for information on Medicaid eligibility, eligibility verification and the Eligibility Verification System (EVS).

e. Lock-in Program: When a recipient has shown patterns of abuse/misuse of Nevada Medicaid benefits, or the DHCFP has determined that the recipient requires close medical management, the recipient may be "locked-in" to a specific pharmacy and/or provider. This means that Medicaid will only pay for controlled substance prescriptions/medical services at a single pharmacy/provider.

1. Criteria that is evaluated by the DHCFP when determining if a recipient should be locked in to a specific pharmacy begins with the number of controlled substance prescriptions filled in 60 days.

   If the recipient has filled ten or more controlled substance prescriptions in the past 60-day period (includes controlled substance pharmaceuticals given in the emergency room) then the clinical review continues with the following criteria:

   a. The recipient has utilized more than one pharmacy in the past 60-day period;

   b. The recipient has utilized more than three physicians in the past 60-day period;

   c. The recipient has utilized the emergency room(s) for receiving controlled substances;

   d. The recipient has been diagnosed with a drug dependency related condition;

   e. The dispensed quantity per prescription of controlled substances appears excessive by the clinical review team; or

   f. The recipient has other noted drug seeking behaviors(s).

2. The POS system will not allow another pharmacy to bill for controlled substance prescriptions, and a message will be given at the time of service to notify the pharmacy that the recipient is locked-in. Any non-controlled substance prescriptions can be filled at any pharmacy.

3. Recipients who are locked-in to one pharmacy can change their locked-in pharmacy at any time by contacting their Medicaid District Office.

4. Pharmacies may call the Technical Call Center for an override to the locked-in pharmacy if:

   a. The locked-in pharmacy is out of stock.

   b. The locked-in pharmacy is closed.

   c. The recipient is out of town and cannot access the locked-in pharmacy.

3. Generic Substitution

Per NRS Chapter 639, if the practitioner has not indicated that generic substitution is prohibited, the pharmacy provider must dispense, in substitution, another drug which is available to him if the other drug:

a. is 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 ingredient 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 the least expensive of the drugs that are available to him for substitution.

The pharmacy provider shall substitute the least expensive of the drugs available to him/her for substitution.

4. Prescriber Brand Certification

Upper Limit cost limitations specified in this Chapter will not apply when a prescriber certifies that a specific brand of medication is medically necessary for a particular patient.

The physician should document in the patient's medical record the need for the brand name product in place of the generic form. The procedure for certification must comply with the following:

a. The certification must be in the physician's own handwriting.

b. Certification must be written directly on the prescription blank.

c. The phrase "Dispense as written" is required on the face of the prescription. For electronically transmitted prescriptions "Dispense as written" must be noted. Not

Criteria for Nevada Medicaid

Incretin Mimetics PA

Executive Summary

Purpose: Promote prudent prescribing

Setting and Population: All members

Targeted Products
Adlyxin® - Lixisenatide
Bydureon® - Exenatide
Byetta® - Exenatide
Soliqua® - Insulin Glargine/Lixisenatide
Tanzeum® - Albiglutide
Trulicity® - Dulaglutide
Victoza® - Liraglutide
Xultophy® - Insulin Degludec/Liraglutide

Approval Duration

- Prior authorization will be for one year

Approval Criteria

Prior Authorization Criteria:

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

1. The recipient is 18 years of age or older
2. The recipient has a diagnosis of type 2 diabetes mellitus
3. The recipient has failed to achieve glycemic control despite an appropriate trial with metformin and/or a sulfonylurea

Quantity Limits

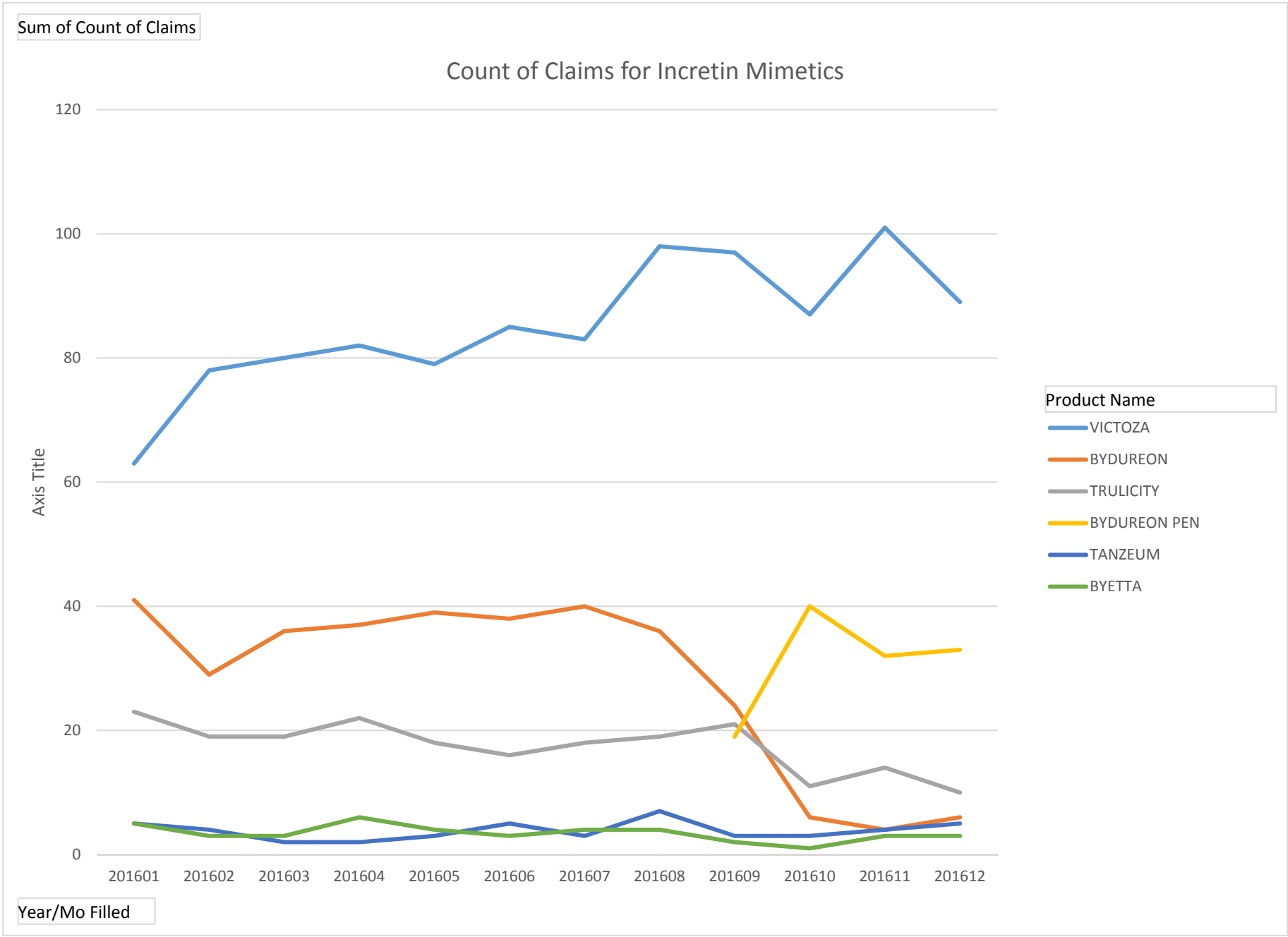
Adlyxin – 20 mcg/day
Bydureon – 2mg/week
Byetta – 20 mcg/day
Soliqua – Insulin glargine 60 units/day with lixisenatide 20 mcg/day
Tanzeum – 50 mg/week
Trulicity – 1.5 mg/week
Victoza – 1.8 mg/day
Xultophy – Insulin degludec 50 units/day with liraglutide 1.8 mg/day

Incretin Mimetics

January 1, 2016 - December 31, 2016

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Qty Total	Sum of Days Supply	Sum of Pharm Paid
BYDUREON	**310**	**336**	**1456**	**10346**	**$198,826.65**
201601	38	41	180	1291	$23,515.44
201602	28	29	124	884	$16,746.32
201603	32	36	152	1078	$20,533.70
201604	32	37	148	1042	$20,009.62
201605	36	39	164	1168	$22,158.28
201606	34	38	176	1262	$23,740.94
201607	37	40	180	1249	$25,065.36
201608	33	36	144	1028	$20,429.38
201609	24	24	108	756	$15,297.69
201610	6	6	24	174	$3,411.18
201611	4	4	24	178	$3,390.84
201612	6	6	32	236	$4,527.90
BYDUREON PEN	**118**	**124**	**520**	**3715**	**$73,678.85**
201609	19	19	84	597	$11,891.48
201610	39	40	168	1199	$23,803.31
201611	29	32	136	985	$19,265.47
201612	31	33	132	934	$18,718.59
BYETTA	**38**	**41**	**96**	**1290**	**$24,746.85**
201601	5	5	10.8	210	$3,838.06
201602	3	3	7.2	90	$1,705.20
201603	3	3	7.2	90	$1,705.20
201604	5	6	14.4	180	$3,410.40
201605	4	4	9.6	120	$2,273.60
201606	3	3	7.2	90	$1,705.20
201607	4	4	8.4	120	$2,357.16
201608	3	4	9.6	120	$2,385.24
201609	2	2	4.8	60	$1,192.62
201610	1	1	2.4	30	$596.31
201611	3	3	7.2	90	$1,788.93
201612	2	3	7.2	90	$1,788.93
TANZEUM	**43**	**46**	**216**	**1522**	**$23,926.75**
201601	5	5	20	142	$2,187.99
201602	4	4	16	112	$1,747.68
201603	2	2	16	112	$1,713.78
201604	2	2	8	56	$867.06
201605	2	3	12	84	$1,300.59
201606	5	5	28	198	$3,021.15

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Qty Total	Sum of Days Supply	Sum of Pharm Paid
201607	3	3	12	84	$1,307.37
201608	7	7	36	254	$3,922.11
201609	3	3	12	86	$1,300.59
201610	3	3	20	140	$2,283.78
201611	4	4	16	114	$1,901.30
201612	3	5	20	140	$2,373.35
TRULICITY	**198**	**210**	**415.5**	**5952**	**$118,640.38**
201601	20	23	46.5	657	$12,848.34
201602	19	19	38.5	539	$10,836.26
201603	18	19	35.5	538	$10,014.22
201604	20	22	44	626	$12,393.80
201605	18	18	34.5	509	$9,723.73
201606	16	16	30.5	455	$8,594.73
201607	17	18	36	508	$10,133.70
201608	18	19	38	536	$10,698.20
201609	18	21	42	596	$12,458.63
201610	11	11	22	312	$6,738.59
201611	13	14	28	394	$8,620.40
201612	10	10	20	282	$5,579.78
VICTOZA	**969**	**1022**	**8619**	**32975**	**$661,579.89**
201601	62	63	519	1952	$39,159.25
201602	75	78	636	2479	$47,994.05
201603	74	80	651	2422	$49,117.50
201604	79	82	681	2638	$51,366.32
201605	76	79	708	2689	$51,323.37
201606	78	85	720	2756	$54,287.50
201607	80	83	717	2688	$53,880.99
201608	91	98	879	3283	$65,531.32
201609	91	97	795	3061	$62,414.41
201610	83	87	699	2755	$55,798.73
201611	98	101	849	3329	$68,865.91
201612	82	89	765	2923	$61,840.54
Grand Total	**1676**	**1779**	**11322.5**	**55800**	**$1,101,399.37**


Sum of Count of Claims
Count of Claims for Incretin Mimetics
120
100
80
60
40
20
0
Axis Title
201601
201602
201603
201604
201605
201606
201607
201608
201609
201610
201611
201612
Year/Mo Filled
Product Name
VICTOZA
BYDUREON
TRULICITY
BYDUREON PEN
TANZEUM
BYETTA

KK. Byetta® (exenatide), Bydureon® (exenatide extended-release) and Victoza® (liraglutide)

Therapeutic Class: Incretin Mimetics
Last Reviewed by the DUR Board: July 26, 2012

Byetta® (exenatide), Bydureon® (exenatide extended-release) and Victoza® (liraglutide) 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.

1. Coverage and Limitations

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

   a. The recipient is 18 years of age or older;

   b. The recipient has a diagnosis of type 2 diabetes mellitus; and

   c. The recipient has failed to achieve glycemic control despite an appropriate trial with metformin and/or a sulfonylurea.

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

Therapeutic Class Overview
Incretin Mimetics & Amylinomimetics

INTRODUCTION

- Diabetes mellitus affects approximately 29.1 million people in the United States (U.S.), which is approximately 9.3% of the population (American Diabetes Association [ADA] Diabetes Basics, 2016).
- Diabetes mellitus is defined as a group of metabolic disorders characterized by hyperglycemia that result from defects in the secretion and action of insulin (ADA Diabetes Basics, 2016).
- The classification of diabetes includes 4 clinical classes: 1) type 1 diabetes mellitus (T1DM) which results from beta-cell (β-cell) destruction, usually leading to absolute insulin deficiency, 2) type 2 diabetes mellitus (T2DM) which results from a progressive insulin secretory defect on the background of insulin resistance, 3) other specific types of diabetes due to other causes, eg, genetic defects in β-cell function, genetic defects in insulin action, diseases of the exocrine pancreas (such as cystic fibrosis), and drug- or chemical-induced (such as in the treatment of human immunodeficiency virus [HIV]/acquired immunodeficiency syndrome [AIDS] or after organ transplantation), and 4) gestational diabetes mellitus (GDM) (diabetes diagnosed during pregnancy that is not clearly overt diabetes) (ADA, 2016).
- Insulin is the standard treatment for T1DM. Pharmacologic options for T2DM include sulfonylureas (SFUs), biguanides, thiazolidinediones (TZDs), meglitinides, alpha-glucosidase inhibitors, dipeptidyl peptidase-4 (DPP-4) inhibitors, glucagon-like peptide-1 (GLP-1) receptor agonists, amylinomimetics, sodium-glucose cotransporter 2 (SGLT2) inhibitors, combination products, and insulin.
- The GLP-1 receptor agonists (albiglutide, dulaglutide, exenatide, exenatide extended-release [ER], liraglutide, and lixisenatide) were developed to mimic the effects of endogenous GLP-1 and are Food and Drug Administration (FDA)-approved as adjunctive therapy to diet and exercise to improve glycemic control in adults with T2DM.
- Pramlintide is the only amylin analog, or amylinomimetic, in the class, and is FDA-approved as an adjunctive treatment with insulin in patients with T1DM or T2DM who have failed to achieve desired glucose control despite optimal insulin therapy. It is a synthetic analog of human amylin, a naturally occurring neuroendocrine hormone synthesized by pancreatic β-cells that contributes to glucose control during the post-prandial period.
- This review will focus on the GLP-1 receptor agonists and pramlintide and their respective FDA-approved indications for treatment of diabetes. Liraglutide (SAXENDA®) is also indicated as adjunctive therapy for chronic weight management; however, the use of liraglutide for this indication will not be included in this review.
- Medispan class: Endocrine and Metabolic Drugs

Table 1. Medications Included Within Class Review

Drug	Manufacturer	FDA Approval Date	Generic Availability
ADLYXIN™ (lixisenatide)	Sanofi-Aventis	07/27/2016	-
BYETTA® (exenatide)	AstraZeneca	04/28/2005	-
BYDUREON® (exenatide ER)	AstraZeneca	01/27/2012	-
SYMLIN® (pramlintide)	AstraZeneca	03/16/2005	-
TANZEUM® (albiglutide)	GlaxoSmithKline	04/15/2014	-
TRULICITY® (dulaglutide)	Eli Lilly	09/18/2014	-
VICTOZA® (liraglutide)	Novo Nordisk	01/25/2010	-

(DRUGS@FDA, 2016)

INDICATIONS

Table 2. Food and Drug Administration Approved Indications

Indication	ADLYXIN (lixisenatide)	BYETTA (exenatide)	BYDUREON (exenatide ER)	SYMLIN (pramlintide)	TANZEUM (albiglutide)	TRULICITY (dulaglutide)	VICTOZA (liraglutide)
T1DM, as an adjunctive treatment in patients who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy.				✔			
T2DM, as an adjunctive treatment in patients who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy.				✔			
Adjunct to diet and exercise to improve glycemic control in adults with T2DM.	✔	✔	✔		✔	✔	✔
Limitations of Use							
Not recommended as first-line therapy for patients inadequately controlled on diet and exercise because of the uncertain relevance of the rodent C-cell tumor findings to humans. Prescribe only to patients for whom the potential benefits are considered to outweigh the potential risk.			✔		✔	✔	✔
Has not been studied in patients with a history of pancreatitis. Consider other antidiabetic therapies in these patients.	✔	✔	✔		✔	✔	✔
Not indicated in treatment of patients with T1DM or for treatment of patients with diabetic ketoacidosis. Not a substitute for insulin in these patients.	✔	✔	✔		✔	✔	✔
Has not been studied in patients with severe gastrointestinal (GI) disease, including severe gastroparesis. Not recommended in patients with pre-existing severe GI disease.					✔	✔	
Has not been studied in patients with gastroparesis. Not recommended in patients with gastroparesis.	✔						
Not studied in combination with prandial/short-acting insulin.	✔	✔			✔		✔
Use with insulin has not been studied and is not recommended.			✔				
Use with basal insulin has not been studied.						✔	

(Prescribing information: BYETTA, 2015; BYDUREON, 2015; SYMLIN, 2015; VICTOZA, 2016; TANZEUM, 2016)

NOTE: Information on indications, mechanism of action, pharmacokinetics, and safety has been obtained from the prescribing information for the individual products, except where noted otherwise.

CLINICAL EFFICACY SUMMARY

Albiglutide

- The approval of albiglutide was based on 8 pivotal trials involving over 5000 patients as a part of the HARMONY phase 3 program (TANZEUM FDA Medical Review, 2014; TANZEUM prescribing information, 2016). The majority of the trials were multicenter (MC), randomized, double-blind (DB), placebo-controlled (PC) or active control (AC) studies in adult patients with inadequately controlled T2DM (HbA1c 7% to 10%); however, 3 trials were open-label (OL). The primary outcome in each trial was the change in HbA1c from baseline at 26 to 104 weeks.
- HARMONY 1 demonstrated that albiglutide 30 mg once weekly was superior to placebo in patients taking concurrent pioglitazone with or without metformin at 52 weeks, with a mean reduction in HbA1c of 0.8% (Reusch et al, 2014).
- HARMONY 2 compared both albiglutide 30 mg and 50 mg once weekly to placebo in patients treated with diet and exercise alone and found that both were superior to placebo at 52 weeks. The least squares mean difference from placebo in HbA1c was -0.84% with the 30 mg dose and -1.04% with the 50 mg dose (Nauck et al, 2016).
- HARMONY 3 demonstrated that albiglutide 30 mg to 50 mg once weekly was superior to placebo, sitagliptin 100 mg once daily, and glimepiride 2 to 4 mg daily in patients taking concurrent metformin at 2 years, with a mean reduction in HbA1c of 0.6% (Ahren et al, 2014).
- HARMONY 4 was an OL trial comparing albiglutide (30 mg to 50 mg once weekly) to protocol titrated insulin glargine in patients taking concurrent metformin with or without an SFU. In this study, albiglutide demonstrated noninferiority to insulin glargine in HbA1c improvement at 52 weeks (Weissman et al, 2014).
- HARMONY 5 compared albiglutide (30 mg to 50 mg once weekly) to placebo and pioglitazone (30 mg to 45 mg per day) in patients taking concurrent metformin and glimepiride. At week 52, albiglutide did not meet the pre-specified noninferiority margin compared to pioglitazone; however, it was superior to placebo and had a mean reduction in HbA1c of 0.6% (Home et al, 2015).
- HARMONY 6, another OL trial, demonstrated that albiglutide 30 mg to 50 mg once weekly was noninferior to insulin lispro 3 times daily in patients taking concurrent pioglitazone with or without metformin at 26 weeks, with a mean reduction in HbA1c of 0.8% (Rosenstock et al, 2014a).
- HARMONY 7 was an OL study comparing albiglutide 50 mg once weekly to liraglutide 1.8 mg daily in patients taking concomitant metformin, TZD, SFU, or a combination of the medications. At week 32, the mean model adjusted change in HbA1c was -0.78% with albiglutide and -0.99% with liraglutide. Albiglutide failed to meet noninferiority (P=0.085) (Pratley et al, 2014).
- HARMONY 8 demonstrated that albiglutide 30 mg to 50 mg was superior to sitagliptin 25 to 100 mg in patients with impaired renal function on concurrent agents or lifestyle treatment at 26 weeks, with a mean reduction in HbA1c of 0.8% compared to a reduction of 0.5% with sitagliptin (Leiter et al, 2014).

Dulaglutide

- The approval of dulaglutide was based on 6 pivotal trials enrolling over 3,000 patients as a part of the AWARD phase 3 program. Trials evaluated the use of dulaglutide 0.75 mg and 1.5 mg strengths. The primary outcome in each trial was the change in HbA1c from baseline to 26 through 52 weeks.
- AWARD-1 demonstrated that once weekly dulaglutide resulted in significantly larger improvements in HbA1c at 26 weeks compared to placebo and exenatide in patients taking maximally tolerated doses of metformin and pioglitazone (Wysham et al, 2014).
- AWARD-2 was an OL study that demonstrated superiority of dulaglutide 1.5 mg once weekly and noninferiority of dulaglutide 0.75 mg once weekly compared to daily insulin glargine in terms of HbA1c reduction from baseline to week 52 (Giorgino et al, 2015).
- AWARD-3 was a DB study that demonstrated superiority of dulaglutide 0.75 mg and 1.5 mg once weekly to metformin in patients inadequately treated with diet and exercise with or without submaximal dosing of at least 1 oral antidiabetic drug (OAD). At 26 weeks, changes from baseline HbA1c were 0.78%, 0.71%, and 0.56% for dulaglutide 1.5 mg, dulaglutide 0.75 mg, and metformin, respectively (Umpierrez et al, 2014).
- AWARD-4 was an OL, 52-week, noninferiority study which found that dulaglutide once-weekly (both 1.5 mg and 0.75 mg strengths) in combination with insulin lispro resulted in significantly greater improvement in glycemic control than insulin glargine in combination with insulin lispro (P=0.005 and P=0.015 for dulaglutide 1.5 mg and 0.75 mg, respectively) (Blonde et al, 2015).
- AWARD-5 was a DB trial that compared placebo, once-weekly dulaglutide (0.75 mg and 1.5 mg), and sitagliptin 100 mg once daily in uncontrolled metformin-treated patients. At weeks 52 and 104, both dulaglutide strengths were superior to sitagliptin in terms of HbA1c reduction from baseline (P<0.001 for all comparisons) (Nauck et al, 2014; Weinstock et al, 2015).

- AWARD-6 was an OL trial which demonstrated that, in patients taking concurrent metformin, dulaglutide 1.5 mg once weekly was noninferior to liraglutide once daily in HbA1c reduction from baseline to week 26 (Dungan et al, 2014).

Exenatide

- The efficacy of exenatide as add-on therapy to metformin alone, an SFU alone, or metformin in combination with an SFU was evaluated in 3 PC, 30-week, randomized controlled trials (RCTs). In all trials, there were significant decreases in HbA1c with exenatide compared to placebo (P<0.001, P<0.002, and P<0.0001, respectively) (Buse et al, 2004; DeFronzo et al, 2005; Kendall et al, 2005). Extensions of these 30-week trials demonstrated that the benefits of exenatide are sustained (Blonde et al, 2006; Buse et al, 2007; Klonoff et al, 2008; Ratner et al, 2006; Riddle et al, 2006).
- A trial evaluating exenatide as add-on therapy in patients currently taking a TZD found that at week 16, exenatide significantly decreased HbA1c (P<0.001), fasting plasma glucose (FPG) (P<0.001), and body weight (P<0.001) compared to placebo (Zinman et al, 2007).
- When exenatide was compared to glyburide as add-on therapy to metformin, exenatide significantly decreased body weight and body mass index (BMI) (P<0.001 for both), whereas the SFU caused significant increases in both (P<0.05 for both). Both treatments significantly decreased HbA1c, FPG, and postprandial plasma glucose (PPG) (exenatide; P<0.001 for all; glyburide; P<0.001 for all). Only exenatide significantly improved insulin resistance (P<0.01) and β-cell function (P<0.05) (Derosa et al, 2010).
- The EUREXA study compared the efficacy of exenatide and glimepiride as add-on therapy to metformin. Patients receiving exenatide exhibited greater reductions in HbA1c from baseline (-0.36%), compared to those receiving glimepiride (-0.21%; P=0.002) (Gallwitz et al, 2012).
- Several trials have compared exenatide to insulin therapy as add-on therapy to metformin and/or an SFU (Bunck et al, 2009; Bunck et al, 2010; Davies et al, 2009; Heine et al, 2005; Nauck et al, 2007; Secnik et al, 2006). Similar improvements in HbA1c between treatments were observed in 3 of the trials while mixed results were observed for decreases in FPG. Specifically, in 2 trials, insulin therapy was “superior” in decreasing FPG (P value not reported and P<0.0001), while in another trial there was no difference between the 2 treatments (P=0.689). Insulin therapy was associated with an increase in body weight compared to a decrease with exenatide (Bunck et al, 2009; Heine et al, 2005; Nauck et al, 2007). Patient-reported health outcome measures demonstrated no differences between exenatide or insulin therapy; both achieved significant improvements from baseline. However, neither treatment improved Diabetes Treatment Flexibility Scores (P=0.93 for both) (Secnik et al, 2006).
- Exenatide once weekly was also compared to daily insulin glargine in diabetic patients inadequately controlled with OADs. Following 26 weeks of therapy, exenatide was found to be statistically noninferior to insulin glargine for the change in HbA1c from baseline to endpoint (Inagaki et al, 2012).

Exenatide ER

- Approval of exenatide ER in the management of T2DM was based on the clinical evidence for safety and efficacy derived from the DURATION trials (1 through 5). Exenatide ER was added to existing antidiabetic regimens in 4 of the 5 trials (1, 2, 3, and 5). In contrast, DURATION-4 compared exenatide ER, metformin, pioglitazone, and sitagliptin all as monotherapy (Bergenstal et al, 2010; Blevins et al, 2011; Diamant et al, 2010; Drucker et al, 2008; Russell-Jones et al, 2012). Overall, exenatide ER as add-on therapy to existing antidiabetic regimens significantly decreased HbA1c compared to exenatide (P<0.005), sitagliptin (P<0.0001), pioglitazone (P=0.0165), and insulin therapy (P=0.017), with no increased risk of hypoglycemia. In terms of decreases in body weight, exenatide ER was “superior” compared to sitagliptin (P=0.0002) and pioglitazone (P<0.0001), and similar compared to exenatide (P=0.89) (Bergenstal et al, 2010; Blevins et al, 2011; Drucker et al, 2008). As expected, GI-related adverse events (AEs) were reported more commonly with the incretin-based therapies. When compared to exenatide, exenatide ER was associated with lower incidences of nausea (14.0% vs. 35.0%) and vomiting (4.7% vs. 8.9%), and higher incidences of diarrhea (9.3% vs. 4.1%) and injection site-related AEs (13% vs. 10%) (Blevins et al, 2011).
- In the DURATION-4 trial, the decrease in HbA1c achieved with exenatide ER monotherapy was “superior” compared to sitagliptin (P<0.001) and similar compared to metformin (P=0.62) and pioglitazone (P=0.328). Exenatide ER and metformin were similar in terms of associated decreases in body weight, with exenatide ER achieving “superiority” compared to sitagliptin and pioglitazone. Overall, exenatide ER was associated with more GI-related AEs, with the exception of diarrhea which occurred at the highest frequency in patients receiving metformin (Diamant et al, 2010).
- In a post-hoc analysis of 4 clinical trials, patients were treated with weekly exenatide for 52 weeks. Patients had significant lowering of HbA1c, blood pressure and low density lipoprotein (LDL) levels without an increase in weight or hypoglycemia (Bergenstal et al, 2013).

- The DURATION-6 trial compared HbA1c reductions between liraglutide once daily and exenatide once weekly in patients with T2DM previously treated with lifestyle modifications and oral agents. Both therapies resulted in improvements in glycemic control; however, greater reductions were noted with liraglutide (Buse et al, 2013).

Liraglutide

- Approval of liraglutide in the management of T2DM was based on the clinical evidence for safety and efficacy derived from the LEAD trials (1 through 6). The LEAD trials evaluated liraglutide monotherapy (LEAD-3); add-on therapy to an SFU (LEAD-1), metformin (LEAD-2), metformin plus a TZD (LEAD-4), metformin plus an SFU (LEAD-5); and monotherapy head-to-head with exenatide (LEAD-6).
- In LEAD-1, liraglutide was compared to placebo or rosiglitazone as add-on therapy to an SFU. After 26 weeks, liraglutide (0.6, 1.2, and 1.8 mg per day) significantly decreased HbA1c compared to placebo (P<0.0001 for all), with only higher doses achieving "superiority" compared to rosiglitazone (P<0.001 for both) (Marre et al, 2009).
- In LEAD-2, liraglutide was compared to placebo and an SFU as add-on therapy to metformin. Liraglutide significantly decreased HbA1c compared to placebo; however, similar decreases were observed with liraglutide compared to the SFU. Liraglutide was associated with significant decreases in body weight compared to placebo (P<0.01) and the SFU (P<0.001) (Nauck et al, 2009). Results of an 18-month OL extension trial were consistent with the DB study (Nauck et al, 2013).
- In LEAD-3, liraglutide was compared to an SFU as monotherapy, and liraglutide was "superior" in decreasing HbA1c (P=0.0014 and P<0.0001 for liraglutide 1.2 mg and 1.8 mg, respectively). In addition, increases in body weight were reported with the SFU, while liraglutide significantly decreased body weight (P=0.027) (Garber et al, 2009). In a 1-year extension trial, patients continuing liraglutide for a total of 2 years maintained significant improvements in HbA1c compared to the SFU (Garber et al, 2011).
- In LEAD-4 and LEAD-5, liraglutide was compared to placebo as add-on therapy to metformin plus an SFU and to a TZD. LEAD-5 also had an OL arm of insulin therapy. Results achieved with liraglutide in terms of decreases in HbA1c, body weight, and FPG compared to placebo were similar to those observed in the other LEAD trials (Russell-Jones et al, 2009; Zinman et al, 2009). When compared to insulin therapy, decreases in HbA1c (P=0.0015) and body weight (P<0.001) and improvements in β-cell function (P=0.0019) were significantly greater with liraglutide. It was noted that decreases in PPG were not different between the 2 treatments, and the likelihood of patients achieving FPG goals were also similar (Russell-Jones et al, 2009).
- LEAD-6 was a head-to-head trial comparing liraglutide to exenatide as add-on therapy to existing antidiabetic treatment regimens. Liraglutide significantly decreased HbA1c compared to exenatide (1.12% vs 0.79%; P<0.0001), and a significantly greater proportion of patients receiving liraglutide achieved HbA1c goals of <7%. Significant decreases in FPG were also achieved with liraglutide (P<0.0001); however, exenatide significantly decreased PPG after breakfast and dinner (P<0.0001 and P=0.0005) (Buse et al, 2009). A 14-week, extension trial revealed that patients who were switched from exenatide to liraglutide achieved additional glycemic control and cardiometabolic benefits (Buse et al, 2010).

Lixisenatide

- Lixisenatide 20 mcg once daily was evaluated as monotherapy, in combination with OADs, and in combination with basal insulin (with or without OADs). Its efficacy was compared with placebo, exenatide, and insulin glulisine. The primary endpoint, the difference in change in HbA1c from baseline to trial end between the lixisenatide and comparator groups, was assessed at varying time points ranging between 12 and 26 weeks.
- GetGoal-Mono found that lixisenatide 20 mcg once daily as monotherapy resulted in significantly larger improvements in HbA1c at 12 weeks compared to placebo in patients with T2DM inadequately controlled on diet and exercise (P<0.0001) (Fonseca et al, 2012).
- GetGoal-F1 was a DB study which found that lixisenatide 20 mcg once daily as add-on therapy to metformin was superior vs. placebo in terms of HbA1c reduction from baseline to week 24. The least squares mean change from baseline was -0.26% for the placebo group vs. -0.72% for the lixisenatide group. The difference vs. placebo was -0.46% (P<0.0001) (Adlyxin prescribing information, 2016; Bolli et al, 2014).
- GetGoal-M-Asia demonstrated superiority of lixisenatide 20 mcg once daily as add-on therapy to metformin with or without an SFU compared to placebo in terms of HbA1c reduction from baseline to week 24 (Yu et al, 2014).
- GetGoal-S was a 24-week, DB study which found that lixisenatide 20 mcg once daily in combination with an SFU with or without metformin resulted in significantly greater improvement in glycemic control than placebo; the difference from placebo in change in HbA1c was -0.58% (P<0.0001) (Adlyxin prescribing information, 2016; Rosenstock et al, 2014b).

- GetGoal-P was a 24-week, DB study which found that lixisenatide 20 mcg once daily in combination with pioglitazone or without metformin resulted in significantly greater improvement in glycemic control than placebo; the difference from placebo in change in HbA1c was -0.48% (P<0.0001) (Adlyxin prescribing information, 2016; Pinget al, 2013).
- In GetGoal-Duo 1, lixisenatide was compared to placebo as add-on therapy to basal insulin and metformin with or without a TZD. Treatment with lixisenatide resulted in a significant reduction in HbA1c at week 24 vs. placebo (Riddle et al, 2013a).
- In GetGoal-L, lixisenatide was compared to placebo as add-on therapy to basal insulin with or without metformin while in Get-Goal-L-Asia, lixisenatide was compared to placebo as add-on therapy to basal insulin with or without an SFU. Both studies found that lixisenatide was superior to placebo in terms of HbA1c reduction from baseline to week 24 (Riddle et al, 2013b; Seino et al, 2012).
- GetGoal-Duo 2 was a 26-week, OL trial that compared lixisenatide to insulin glulisine once daily or 3 times daily for intensification of optimized insulin glargine ± metformin in patients with T2DM uncontrolled on basal insulin ± OADs (ie, an SFU and/or a DPP-4 inhibitor, and/or a glinide). Lixisenatide was found to be noninferior to both insulin glulisine regimens in terms of HbA1c reduction from baseline to week 26. However, lixisenatide provided less HbA1c reduction than insulin glulisine 3 times daily and the difference was statistically significant; the least squares mean difference of lixisenatide vs. insulin glulisine 3 times daily was 0.23 (P=0.0002) (Adlyxin prescribing information, 2016; Rosenstock et al, 2016).
- GetGoal-X was a 24-week, OL trial that evaluated lixisenatide vs. exenatide twice daily as add-on therapy to metformin. Lixisenatide met the pre-specified noninferiority margin vs. exenatide twice daily for the difference in HbA1c reduction from baseline to week 24. However, lixisenatide provided less HbA1c reduction than exenatide and the difference was statistically significant; the least squares mean difference vs. exenatide was 0.17% (P=0.0175) (Adlyxin prescribing information, 2016; Rosenstock et al, 2013).

Cardiovascular (CV) outcomes

- Several RCTs designed to assess the impact of incretin-based therapy on CV outcomes are in progress, including trials with exenatide (EXSCEL, results expected in 2018), albiglutide (results expected in 2019), and dulaglutide (REWIND, results expected in 2019) (ClinicalTrials.gov, 2016).
- A MC, DB, PC, RCT (LEADER trial; N = 9340) was conducted to evaluate the long-term effects of liraglutide vs. placebo on CV outcomes in patients with T2DM and high CV risk. The median follow-up was 3.8 years. It was found that the primary composite outcome (CV death, non-fatal myocardial infarction [MI], or non-fatal stroke) occurred in fewer patients in the liraglutide group (13.0%) vs. the placebo group (14.9%) (hazard ratio [HR], 0.87; 95% confidence interval [CI], 0.78 to 0.97; P<0.001 for noninferiority; P=0.01 for superiority). Fewer patients died from CV causes in the liraglutide group (4.7%) vs. the placebo group (6.0%) (HR, 0.78; 95% CI, 0.66 to 0.93; P=0.007). The rate of death from any cause was lower in the liraglutide group (8.2%) vs. the placebo group (9.6%) (HR, 0.85; 95% CI, 0.74 to 0.97; P=0.02).The rates of nonfatal MI, nonfatal stroke, and hospitalization for heart failure were nonsignificantly lower in the liraglutide group than in the placebo group (Marso et al, 2016a).
- A MC, DB, PC, RCT (ELIXA trial; N = 6068) evaluated the long-term effects of lixisenatide vs. placebo on CV outcomes in patients with T2DM who had a recent acute coronary syndrome (ACS) event within 180 days of screening. The median follow-up was 25 months. It was found that the primary endpoint event (a composite of the first occurrence of any of the following: death from CV causes, non-fatal MI, non-fatal stroke, or hospitalization for unstable angina) occurred in 13.4% of patients in the lixisenatide group and 13.2% in the placebo group (HR, 1.02; 95% CI, 0.89 to 1.17), which demonstrated noninferiority of lixisenatide to placebo (P<0.001), but did not demonstrate superiority (P=0.81).The rates of the individual CV components of the primary endpoint were similar between the lixisenatide and placebo groups (Pfeffer et al, 2015).
- Semaglutide, a once-weekly GLP-1 receptor agonist in the pipeline, demonstrated reduced CV risks in the SUSTAIN-6 trial when compared to placebo. A larger confirmatory trial is planned by Novo Nordisk, which is also expected to gather additional data on retinopathy complications reported in earlier studies (Marso et al 2016b, Skydsgaard 2016).

Meta-analyses

- Meta-analyses and Cochrane Reviews evaluating GLP-1 receptor agonists have found that they lead to decreases in HbA1c of ~1%, with greater decreases in body weight and systolic blood pressure compared to placebo and other antidiabetic agents (Wang et al, 2013; Shyangdan et al, 2011; Sun et al, 2015).
- Meta-analyses have revealed that incretin-based therapies are not associated with an increased risk of CV events (Monami et al, 2014b) or pancreatitis (Monami et al, 2014a) compared to placebo or other antidiabetic agents.

Pramlintide

- The safety and efficacy of pramlintide in patients with T1DM have been established in PC, RCTs when administered in addition to existing insulin regimens. In a 52-week, DB, MC, PC study, pramlintide significantly reduced HbA1c from

baseline compared to placebo (-0.39% vs -0.12%; P=0.0071) and was also associated with a significant weight loss compared to placebo (P<0.001) (Whitehouse et al, 2002). In a second 52-week study, patients experienced a significant reduction in HbA1c when receiving pramlintide 60 mcg 3 times daily (-0.41 vs. -0.18%; P=0.012) and pramlintide 60 mcg 4 times daily (-0.39 vs -0.18%; P=0.013) at 26 weeks. Treatment with pramlintide 3 or 4 times daily continued to maintain reductions in HbA1c at 52 weeks compared to treatment with placebo (P=0.011 and P=0.001 for the 3- and 4 times daily dosing, respectively) (Ratner et al, 2004).

- A meta-analysis of 3 studies assessing the effect of pramlintide as adjunctive therapy in patients with T1DM reported that, compared to placebo, pramlintide resulted in significant reductions in HbA1c and body weight from baseline to week 26 (0.3% and 1.8 kg, respectively; both P≤0.0009) (Ratner et al, 2005).
- A systematic review and meta-analysis of 8 PC, RCTs assessed the effect of pramlintide in patients with T2DM and in obese patients without diabetes. Four T2DM studies (N=930; 16 to 52 weeks duration) and 4 obesity studies (N=686; 6 to 24 weeks duration) were included. Of the T2DM studies, 3 studies used meal-time placebo as the comparator while 1 study used rapid-acting insulin as the comparator. When endpoint data from all T2DM studies were combined, pramlintide was associated with a small but significant reduction in HbA1c (mean difference: -0.33% [95% CI, -0.51 to -0.14]; P=0.0004). In the meta-analysis of the T2DM studies, patients on pramlintide were 1.52 times more likely to reach the HbA1c goal ≤7% than patients in the control group; however, this difference was not significant (P=0.18). Pramlintide was associated with a significant change in body weight in patients with T2DM compared to the control group (-2.57 kg [95% CI, -3.44 to -1.70]; P<0.00001) (Singh-Franco et al, 2011).

Clinical Guidelines

- According to current clinical guidelines, metformin remains the cornerstone of most T2DM treatment regimens. The incretin mimetics are recommended as a potential second-line treatment option to be added to metformin in patients not achieving glycemic goals. Clinical guidelines note a lower rate of hypoglycemia, established efficacy and safety profile when used in combination with metformin, demonstrated effectiveness in reducing PPG, and the potential for weight loss as advantages associated with the incretin mimetics compared to other antidiabetic agents. No one incretin mimetic is recommended or preferred over another. Current clinical guidelines do not support the use of amylinomimetics in the management of T2DM. Among T1DM patients, the addition of pramlintide to first-line insulin therapy may be considered to enhance glycemic control and to assist with weight management (ADA, 2016; Garber et al, 2016; Inzucchi et al, 2015).

SAFETY SUMMARY

- Contraindications:
  - o Hypersensitivity to the drug or any of its components.
  - o BYDUREON (exenatide ER), TANZEUM (albiglutide), TRULICITY (dulaglutide), and VICTOZA (liraglutide) are contraindicated in patients with a personal or family history of medullary thyroid carcinoma (MTC) or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2).
  - o SYMLIN (pramlintide): Gastroparesis and hypoglycemia unawareness.
- Boxed warnings:
  - o BYDUREON (exenatide ER), TANZEUM (albiglutide), TRULICITY (dulaglutide) and VICTOZA (liraglutide)
    - ▪ Cause thyroid C-cell tumors in rats and mice. It is unknown if they cause thyroid C-cell tumors including MTC in humans.
    - ▪ They are contraindicated in patients with a personal or family history of MTC or in patients with MEN 2.
  - o SYMLIN (pramlintide)
    - ▪ Use with insulin has been associated with an increased risk of severe hypoglycemia, particularly in patients with T1DM.
- Warnings/Precautions:
  - o ADLYXIN (lixisenatide), BYETTA (exenatide), BYDUREON (exenatide ER), TANZEUM (albiglutide), TRULICITY (dulaglutide), and VICTOZA (liraglutide)
    - ▪ Pancreatitis – There have been reports of fatal and nonfatal hemorrhagic or necrotizing pancreatitis. Consider other therapies in patients with a history of pancreatitis.
    - ▪ Hypoglycemia – Risk is increased when used with insulin or insulin secretagogue.
    - ▪ Renal impairment – There have been post-marketing reports of altered renal function including increased serum creatinine, renal impairment, worsened chronic renal failure and acute renal failure, sometimes requiring hemodialysis or kidney transplantation.
  - o BYETTA (exenatide), BYDUREON (exenatide ER), and TRULICITY (dulaglutide)
    - ▪ Severe GI disease – Use is not recommended.
  - o ADLYXIN (lixisenatide), BYETTA (exenatide), and BYDUREON (exenatide ER)

    - Immunogenicity – Patients can develop antibodies; glycemic control may be lost. Consider other therapies if there is worsening of glycemic control or failure to achieve the glycemic target.
  - ADLYXIN (lixisenatide), BYETTA (exenatide), SYMLIN (pramlintide), and VICTOZA (liraglutide)
    - Pens should never be shared between patients, even if the needle is changed. Pen-sharing poses a risk for transmission of blood-borne pathogens.
  - SYMLIN (pramlintide)
    - Hypoglycemia – Risk is increased when used with insulin or insulin secretagogue.
- Adverse events:
  - The most common AEs seen with these agents are nausea and vomiting which generally decrease over time.
- Drug Interactions:
  - Orally administered drugs – Absorption of oral drugs can potentially be delayed. If absorption is critical to an oral drug's effectiveness, it should be given 1 hour before ADLYXIN (lixisenatide) or BYETTA (exenatide), and 1 hour before or 2 hours after SYMLIN (pramlintide).
  - Insulin – Mixing SYMLIN (pramlintide) and insulin can alter the pharmacokinetics of both products, leading to inadequate glucose control or hypoglycemia. They should never be mixed.
- Risk Evaluation and Mitigation Strategy (REMS) programs:
  - TANZEUM (albiglutide), TRULICITY (dulaglutide), and VICTOZA (liraglutide)
    - The REMS programs for these agents include a communication plan for alerting healthcare professionals about the risk of acute pancreatitis and the potential risk of MTC.
  - SYMLIN (pramlintide)
    - The REMS program includes a communication plan informing healthcare providers of the risk of severe hypoglycemia when this agent is used in combination with insulin as well as the importance of proper patient selection for treatment with this drug.

DOSING AND ADMINISTRATION

Table 3. Dosing and Administration

Drug	Dosage Form: Strength	Usual Recommended Dose	Other Dosing Considerations	Administration Considerations
ADLYXIN (lixisenatide)	Injection (50 mcg/mL): 3 mL prefilled pen (14 pre-set doses; 10 mcg per dose) Injection (100 mcg/mL): 3 mL prefilled pen (14 pre-set doses; 20 mcg per dose)	Initiate at 10 mcg subcutaneously (SC) once daily for 14 days; on day 15, increase dosage to 20 mcg once daily	--	Inject in the abdomen, thigh, or upper arm. Administer within 1 hour before the first meal of the day, preferably the same meal each day.
BYETTA (exenatide)	Injection (250 mcg/mL): 1.2 mL prefilled pen, 5 mcg per dose, 60 doses 2.4 mL prefilled pen, 10 mcg per dose, 60 doses	Initiate at 5 mcg SC twice daily; increase to 10 mcg twice daily after 1 month based on clinical response.	--	Inject in the thigh, abdomen, or upper arm. Inject within 60 minutes prior to morning and evening meals (or before the 2 main meals of the day, approximately 6 hours or more apart).
BYDUREON (exenatide ER)	Injection tray: Single-dose vial containing 2 mg exenatide powder and 1 prefilled syringe delivering 0.65 mL diluent	Administer 2 mg SC once every 7 days (weekly).	If a dose is missed, administer as soon as noticed as long as the next dose is due at least 3 days	Inject in the thigh, abdomen, or upper arm. Administer at any time of day with or

Drug	Dosage Form: Strength	Usual Recommended Dose	Other Dosing Considerations	Administration Considerations
	Pen injection: Single-dose pen containing 2 mg exenatide per 0.65 mL diluent		later.	without meals. Administer immediately after the powder is suspended.
SYMLIN (pramlintide)	Injection (1,000 mcg/mL): 1.5 mL disposable multidose SYMLINPen® 60 pen-injector for 15, 30, 45, and 60 mcg doses; 2.7 mL disposable multidose SYMLINPen 120 pen-injector for 60 and 120 mcg doses	T1DM 15 mcg SC immediately prior to major meals. Increase the dose to the next increment (30 mcg, 45 mcg, or 60 mcg) when no clinically significant nausea has occurred for at least 3 days. T2DM 60 mcg SC immediately prior to major meals. Increase dose to 120 mcg when no clinically significant nausea has occurred for 3 days.	Reduce preprandial, rapid-acting or short-acting insulin dosages, including fixed-mix insulins (70/30) by 50%. Adjust insulin doses to optimize glycemic control once the target dose of SYMLIN is achieved and nausea (if experienced) has subsided. Dose should be decreased If significant nausea persists.	Inject in the thigh or abdomen. Bring to room temperature prior to injecting. Administer immediately prior to each major meal (≥250 kcal or containing ≥30 g of carbohydrate).
TANZEUM (albiglutide)	Single-use pen for injection: 30 mg, 50 mg	30 mg SC once weekly; dose may be increased to 50 mg once weekly if the glycemic response is inadequate.	If a dose is missed, administer as soon as possible if within 3 days and resume dosing on usual day of administration. If it is more than 3 days after the missed dose, skip dose, and administer at next regularly scheduled weekly dose.	Inject in the thigh, abdomen, or upper arm. Administer on the same day each week. Day may be changed if necessary, so long as the previous dose was administered ≥4 days prior. Wait 15 minutes for the 30-mg pen and 30 minutes for the 50-mg pen after the lyophilized powder and diluent are mixed to ensure reconstitution.
TRULICITY (dulaglutide)	Single-dose pen or prefilled syringe: 0.75 mg/0.5 mL and 1.5 mg/0.5 mL	0.75 mg SC once weekly; dose can be increased to 1.5 mg once weekly for additional glycemic control.	If a missed dose occurs and there are at least 3 days (72 hours) until the next scheduled dose, administer the dose. If less	Inject in the thigh, abdomen, or upper arm. May be given any time of day, with or without food.

Drug	Dosage Form: Strength	Usual Recommended Dose	Other Dosing Considerations	Administration Considerations
			than 3 days remain before the next scheduled dose, skip the missed dose and administer the next dose on the regularly scheduled day.	The day of weekly administration may be changed if necessary as long as the last dose was administered 3 or more days before.
VICTOZA (liraglutide)	Injection (6 mg/mL): 3 mL pre-filled, multi-dose pen that delivers doses of 0.6 mg, 1.2 mg, or 1.8 mg	0.6 mg SC once daily for 1 week, then increase the dose to 1.2 mg once daily. If the 1.2 mg dose does not result in acceptable glycemic control, the dose can be increased to 1.8 mg once daily.	The initial dose is intended to reduce GI symptoms during initial titration, and is not effective for glycemic control.	Inject in the thigh, abdomen, or upper arm. Administer once daily at any time of day, independently of meals. If VICTOZA is stopped for more than 3 days, start at 0.6 mg per day again.

SPECIAL POPULATIONS

Table 4. Special Populations

Drug	Population and Precaution				
	Elderly	Pediatrics	Renal Dysfunction	Hepatic Dysfunction	Pregnancy and Nursing
ADLYXIN (liraglutide)	No overall differences in efficacy and safety have been observed in older patients, but greater sensitivity in some older individuals cannot be ruled out.	Safety and efficacy have not been established.	No dose adjustment is recommended in patients with mild (estimated glomerular filtration rate [eGFR] 60 to 89 mL/min/1.73 m^2) or moderate (eGFR 30 to 59 mL/min/1.73 m^2) renal impairment, but close monitoring for AEs and for changes in renal function is recommended. Clinical experience in patients with severe renal impairment (eGFR 15 to 29 mL/min/1.73 m^2) is extremely limited; patients should be closely monitored	No pharmacokinetic study has been performed in patients with acute or chronic hepatic impairment. Hepatic dysfunction is not expected to affect the pharmacokinetics of ADLYXIN.	There are no adequate and well-controlled studies in pregnant women. GLP-1 receptor agonists should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not known whether these drugs are excreted in human milk.

Drug	Population and Precaution				
	Elderly	Pediatrics	Renal Dysfunction	Hepatic Dysfunction	Pregnancy and Nursing
			for GI AEs and for changes in renal function. There is no therapeutic experience in patients with end-stage renal disease (ESRD) (eGFR <15 mL/min/1.73 m^2); it is not recommended to use ADLYXIN in this population.		
BYETTA (exenatide)	No differences in safety or efficacy were observed between elderly and younger patients; however, because elderly patients are more likely to have decreased renal function, caution is advised when initiating these drugs in the elderly.	Safety and efficacy have not been established.	BYETTA is not recommended for use in patients with ESRD or severe renal impairment (creatinine clearance [CrCL] <30 mL/min). Caution should be applied when initiating or escalating doses from 5 to 10 mcg in patients with moderate renal impairment (CrCL 30 to 50 mL/min).	Hepatic dysfunction is not expected to affect blood concentrations.	Pregnancy category C* There are no adequate and well-controlled studies in pregnant women. GLP-1 receptor agonists should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not known whether these drugs are excreted in human milk.
BYDUREON (exenatide ER)	No differences in safety or efficacy were observed between elderly and younger patients; however, because elderly patients are more likely to have decreased renal function, caution is advised when initiating these drugs in the elderly.	Safety and efficacy have not been established.	BYDUREON is not recommended for use in patients with ESRD or severe renal impairment (CrCL <30 mL/min). Caution is advised in patients with renal transplantation or moderate renal impairment (CrCL 30 to 50 mL/min).	Hepatic dysfunction is not expected to affect blood concentrations.	Pregnancy category C* There are no adequate and well-controlled studies in pregnant women. GLP-1 receptor agonists should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not known whether these drugs are excreted in human milk.

Drug	Population and Precaution				
	Elderly	Pediatrics	Renal Dysfunction	Hepatic Dysfunction	Pregnancy and Nursing
SYMLIN (pramlintide)	No consistent differences in efficacy and safety have been observed in older patients, but greater sensitivity in some older individuals cannot be ruled out.	Safety and efficacy have not been established.	No dose adjustment is recommended.	Use has not been studied in patients with hepatic impairment.	Pregnancy category C* Unknown whether excreted in breast milk; use with caution.
TANZEUM (albiglutide)	No overall differences in efficacy and safety have been observed in older patients, but greater sensitivity in some older individuals cannot be ruled out.	Safety and efficacy have not been established.	No dose adjustment is required in mild, moderate, or severe renal impairment. Experience in patients with severe renal impairment is limited. In clinical trials, GI AEs increased as renal function decreased.	No clinical trials were conducted to examine the effects of mild, moderate, or severe hepatic impairment on the pharmacokinetics of TANZEUM. Therapeutic proteins such as TANZEUM are catabolized by widely distributed proteolytic enzymes, which are not restricted to hepatic tissue; therefore, changes in hepatic function are unlikely to have any effect on the elimination of TANZEUM.	Pregnancy category C* There are no adequate and well-controlled studies in pregnant women. GLP-1 receptor agonists should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not known whether these drugs are excreted in human milk. Consider stopping at least 1 month before a planned pregnancy due to the long washout period.
TRULICITY (dulaglutide)	No overall differences in safety or efficacy have been detected in patients 65 years of age and older. However, greater sensitivity of some older individuals cannot be ruled out.	Safety and efficacy have not been established.	There is limited clinical experience in patients with severe renal impairment or ESRD. TRULICITY should be used with caution, and if these patients experience GI AEs, renal function should be closely monitored.	There is limited clinical experience in patients with mild, moderate, or severe hepatic impairment. Therefore, this drug should be used with caution in these patient populations.	Pregnancy category C* There are no adequate and well-controlled studies in pregnant women. GLP-1 receptor agonists should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not

Drug	Population and Precaution				
	Elderly	Pediatrics	Renal Dysfunction	Hepatic Dysfunction	Pregnancy and Nursing
					known whether these drugs are excreted in human milk.
VICTOZA (liraglutide)	No overall differences in efficacy and safety have been observed in older patients, but greater sensitivity in some older individuals cannot be ruled out.	Safety and efficacy have not been established.	No dose adjustment is recommended for patients with renal impairment. The safety and efficacy of VICTOZA was evaluated in a 26-week clinical study that included patients with moderate renal impairment (eGFR 30 to 60 mL/min/1.73m^2). There is limited experience with this drug in patients with severe renal impairment, including ESRD. There have been postmarketing reports of acute renal failure and worsening of chronic renal failure, which may sometimes require hemodialysis. Caution should be used in patients who experience dehydration.	There is limited experience in patients with mild, moderate, or severe hepatic impairment. Therefore, caution is advised in this patient population. No dose adjustment is recommended for patients with hepatic impairment.	Pregnancy category C* There are no adequate and well-controlled studies in pregnant women. GLP-1 receptor agonists should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not known whether these drugs are excreted in human milk.

* Pregnancy Category C = Risk cannot be ruled out. Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.

CONCLUSION

- The GLP-1 receptor agonists, or incretin mimetics, exenatide (BYETTA), exenatide ER (BYDUREON), albiglutide (TANZEUM), dulaglutide (TRULICITY), liraglutide (VICTOZA), and lixisenatide (ADLYXIN) are incretin-based antidiabetic therapies that are FDA-approved as adjunctive therapy to diet and exercise in adult patients with T2DM. Pramlintide (SYMLIN) is the only agent within the amylinomimetic medication class and is FDA-approved as adjunctive therapy in patients with T1DM or T2DM who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy.
- The incretin mimetics are available as SC injections to be administered in the abdomen, thigh, or upper arm. BYETTA is administered twice daily (60 minutes prior to meals); VICTOZA is administered once daily (independent of meals); and ADLYXIN is administered once daily (1 hour prior to the first meal of the day). BYDUREON, TANZEUM, and

TRULICITY are administered once weekly. SYMLIN is available as a SC injection to be administered immediately prior to each major meal. These agents are currently available as branded products only.

- The incretin mimetics have been studied extensively in combination with, and in comparison to, a variety of antidiabetic therapies. The agents are significantly more effective than placebo in reducing HbA1c, FPG, PPG, and body weight. Efficacy data comparing treatment to an SFU, TZD, DPP-4 inhibitor or insulin is mixed, with the GLP-1 agonists achieving significantly greater or comparable benefits in glycemic outcomes.
- Several CV outcomes trials evaluating GLP-1 receptor agonists in patients with T2DM and high CV risk have been published. The LEADER trial demonstrated reduced CV risk with liraglutide vs. placebo (Marso et al, 2016a), whereas the ELIXA trial did not demonstrate a statistically significant difference between lixisenatide vs. placebo (Pfeffer et al, 2015). Results of the SUSTAIN-6 trial for semaglutide, an agent which has not yet been FDA approved, have also been published (Marso et al, 2016b).
- Overall, the AE profiles of the GLP-1 receptor agonists are similar. With the exception of ADLYXIN and BYETTA, all of the agents have a boxed warning regarding the risk of thyroid C-cell tumors. Other warnings include increased risks of pancreatitis (including fatal and non-fatal hemorrhagic or necrotizing pancreatitis), serious hypersensitivity reactions, immunogenicity, serious hypoglycemia when used in combination with SFUs or insulin, and renal impairment. TANZUEM, TRULICITY, and VICTOZA have REMS programs which include a communication plan for alerting healthcare professionals about the risk of acute pancreatitis and the potential risk of MTC.
- According to current clinical guidelines, metformin remains the cornerstone of most T2DM treatment regimens. The incretin mimetics are recommended as a potential second-line treatment option to be added to metformin in patients not achieving glycemic goals. Clinical guidelines note a lower rate of hypoglycemia, established efficacy and safety profile when used in combination with metformin, demonstrated effectiveness in reducing PPG, and the potential for weight loss as advantages associated with the incretin mimetics compared to other antidiabetic agents. No one incretin mimetic is recommended or preferred over another. Current clinical guidelines do not support the use of amylinomimetics in the management of T2DM. For T1DM, the addition of pramlintide to first-line insulin therapy may be considered to enhance glycemic control and to assist with weight management (ADA, 2016; Garber et al, 2016; Inzucchi et al, 2015).

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Publication Date: December 1, 2016

Criteria for Nevada Medicaid

Lumacaftor/Ivacaftor (Orkambi®)

Executive Summary

Purpose: Promote prudent prescribing

Setting and Population: All claims through point of sale

Targeted Products

Lumacaftor/ivacaftor (Orkambi®)

Approval Duration

- Prior Authorization approvals will be for one year

Approval Criteria

Prior Authorization Criteria

- 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 ~~12~~6 years of age or older; and
  c. The recipient is homozygous for the F508del mutation in the CFTR gene; and
  d. The requested dose is two tablets every 12 hours; or
  e. The requested dose is one tablet every 12 hours in the presence of severe hepatic impairment

Quantity Limits

- Four (4) tablets per day

Orkambi Utilization

January 1, 2016 to December 31, 2016

Year/Mo Filled	Product Name	Route of Admin	Count of Members	Count of Claims	Qty Total	Days Supply	Pharm Paid
201601	ORKAMBI	OR	4	5	560	140	$ 99,666.25
201602	ORKAMBI	OR	4	4	448	112	$ 79,733.00
201603	ORKAMBI	OR	5	6	672	168	$ 119,599.50
201604	ORKAMBI	OR	5	5	560	140	$ 99,666.25
201605	ORKAMBI	OR	3	3	336	84	$ 59,799.75
201606	ORKAMBI	OR	5	6	672	168	$ 119,599.50
201607	ORKAMBI	OR	4	6	672	168	$ 119,599.50
201608	ORKAMBI	OR	5	6	672	168	$ 119,599.50
201609	ORKAMBI	OR	3	3	336	84	$ 59,799.75
201610	ORKAMBI	OR	3	4	448	112	$ 79,733.00
201611	ORKAMBI	OR	3	3	336	84	$ 59,799.75
201612	ORKAMBI	OR	5	5	560	140	$ 99,666.25

HHH. Orkambi® (lumacaftor/ivacaftor)

Therapeutic Class: Cystic Fibrosis Agent
Last Reviewed by the DUR Board: November 5, 2015

Orkambi® (lumacaftor/ivacaftor) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act (SSA) 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 12 years of age or older; and

   c. The recipient is homozygous for the F508del mutation in the CFTR gene; and

   d. The requested dose is two tablets every 12 hours; or

   e. The requested dose is one tablet every 12 hours in the presence of severe hepatic impairment.

2. Prior Authorization Guidelines:

   a. Prior Authorization approvals will be for one year.

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

New Drug Overview
Orkambi® (lumacaftor/ivacaftor)

- **Overview/Summary:** Cystic fibrosis (CF) is a rare, life-threatening autosomal recessive disease. The frequency is approximately 1:2,000 to 3,000 live births. CF is caused by mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene which codes for the CFTR protein.[1] The CFTR protein functions as a channel across the membrane of cells that produce mucus, sweat, saliva, tears and digestive enzymes. The channel transports chloride ions into and out of cells. This transport helps control the movement of water in tissues, necessary for the production of thin, freely flowing mucus which provides a protective coating in the airways, digestive system, reproductive system and other organs and tissues. In addition to chloride, the CFTR gene also transports sodium ions across cell membranes for lung and pancreatic function.[2]

  Typical respiratory manifestations of CF 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 CF-related diabetes. Furthermore, malnutrition due to pancreatic insufficiency may cause rectal prolapse and musculoskeletal disorders. Patients with CF are also at an increased risk of liver disease, infertility, venous thrombosis and nephrolithiasis.[1]

  Orkambi® (lumacaftor/ivacaftor) is a combination product that contains ivacaftor, a potentiator of the CFTR protein as well as lumacaftor, a CFTR corrector. This co-formulated product is the first medication that has been Food and Drug Administration (FDA)-approved to target the underlying cause of CF in patients that are homozygous for the F508del mutation, which is the most prevalent mutation among patients in the United States.[3] It is estimated that of the 30,000 individuals in the United States that have CF, approximately 8,500 have two copies of the F508del mutation.[4]

  The Cystic Fibrosis Foundation (CFF) currently has numerous guidelines available to help with the diagnosis and management of the various complications associated with CF. The most recent guidelines from 2013 that address chronic medications for the maintenance of lung health include dornase alfa, inhaled hypertonic saline, antibiotics such as inhaled tobramycin, inhaled aztreonam or oral azithromycin if *Pseudomonas aeruginosa* is persistently present, and Kalydeco® (ivacaftor).[5] These guidelines have not yet been updated to include this newest agent, Orkambi® (lumacaftor/ivacaftor).

Table 1. Dosing and Administration[1]

Generic Name	Adult Dose	Pediatric Dose	Availability
Lumacaftor/ ivacaftor	Cystic Fibrosis (homozygous for F508del): Tablet: initial, maintenance and maximum, 400 mg/250 mg every 12 hours with fat-containing foods Dosage Adjustment for Patients with Moderate Hepatic Impairment (Child-Pugh Class B): 400 mg/500 mg QAM and 200 mg/125 mg QPM with fat-containing foods Dosage Adjustment for Patients with Severe Hepatic Impairment	Cystic Fibrosis (homozygous for F508del) 6 to ≤11 years of age: Tablet: initial, maintenance and maximum, 200 mg/250 mg every 12 hours with fat-containing foods Cystic Fibrosis (homozygous for F508del) ≥12 years of age: See adult dosing.	Tablet: 100 mg/125 mg 200 mg/125 mg

Generic Name	Adult Dose	Pediatric Dose	Availability
	(Child-Pugh Class C): Use with caution: maximum dose of: 200 mg/125 mg every 12 hours with fat-containing foods Dosage Adjustment for Patients Taking CYP3A Inhibitors: No dosage adjustment required when CYP3A inhibitors are initiated in patients already taking lumacaftor/ivacaftor. However, when initiating lumacaftor/ivacaftor in patients currently taking strong CYP3A inhibitors, reduce dose: One tablet QD for one week then increase to the recommended daily dose of two tablets every 12 hours.		

Evidence-based Medicine

- Several phase II studies were performed with the investigational agent, lumacaftor, both alone and in combination with ivacaftor to evaluate the safety and tolerability of these products in CF individuals over the age of 18 years with the F508del-CFTR mutation.
    - Four doses of lumacaftor were found to have a similar adverse event profile to placebo during a 28 day trial. In addition, this agent was found to reduce sweat chloride values in a dose-dependent manner with only the 100 mg and 200 mg groups achieving statistical significance ($P<0.05$ and $P<0.01$, respectively). There were no significant changes in lung function in any of the dose groups.[6]
    - The second phase II trial, was also a randomized, double-blind, placebo-controlled trial that examined three successive cohorts. The results from each cohort were used to assist with the appropriate dose selection for the subsequent cohort.[7]
        - Cohort 1 (homozygous for the F508del mutation) was randomized to either placebo for 21 days or lumacaftor 200 mg once daily for 14 days followed by the addition of either ivacaftor 150 mg or 250 mg every 12 hours for seven days. For the combination period, mean sweat chloride fell significantly only for those individuals assigned to the lumacaftor 200 mg plus ivacaftor 250 mg group compared with placebo ($P<0.001$). In addition, the change in sweat chloride concentration over the 21-day study period for patients given lumacaftor 200 mg plus ivacaftor 250 mg was -12.6 mmol/L ($P<0.001$) compared to day one and -10.9 mmol/L ($P=0.002$) compared with placebo.
        - Cohorts 2 and 3 (F508del CFTR homozygous and heterozygous individuals) were randomly assigned to either 56 days of placebo or lumacaftor with ivacaftor 250 mg every 12 hours added after 28 days. Results from Cohort 2 and 3 showed that there was no significant decrease in mean sweat chloride concentration during the combination treatment in any treatment group. In Cohort 2, the lumacaftor 600 mg combination group significantly improved FEV1 by 5.6 percentage points ($P=0.013$) compared to placebo from day 1 to 56. In Cohort 3, FEV1 improvement of 7.7 percentage points ($P=0.003$) was observed during the combination treatment period.
    - Phase III studies (TRAFFIC and TRANSPORT) showed that statistically significant mean absolute improvements in FEV_1 compared to placebo, with a range of 2.6 to 4.0 percentage points ($P\leq0.0004$) and a mean relative improvement of 4.3 to 6.7% ($P\leq0.0007$). In addition, the pooled analysis from these phase III trials showed statistically significant reductions of 30 to 39% in the rate of pulmonary exacerbations for those who received the combination

regimens compared to those who received placebo (P≤0.0014) as well as statistically significant improvement in the body mass index (P<0.0001).[8,9]

Key Points within the Medication Class

- According to Current Clinical Guidelines:
  - The most recent guidelines from 2013 that address chronic medications for the maintenance of lung health include dornase alfa, inhaled hypertonic saline, antibiotics such as inhaled tobramycin, inhaled aztreonam or oral azithromycin if Pseudomonas aeruginosa is persistently present, and Kalydeco® (ivacaftor).[5] These guidelines have not yet been updated to include this newest agent, Orkambi® (lumacaftor/ivacaftor).

- Other Key Facts:
  - This is the first medication that specifically targets CF individuals with two copies of the F508del mutation.
  - Safety and effectiveness of this agent in individuals < 12 years of age is unknown at this time.
  - Long term efficacy data is unavailable at this time.

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Criteria for Nevada Medicaid

Buprenorphine/Naloxone and Buprenorphine PA

Executive Summary

Purpose: Promote prudent prescribing of buprenorphine/naloxone and buprenorphine.

Setting and Population: All members

Targeted Products
Buprenorphine/Naloxone
Buprenorphine

Approval Duration

- Prior authorization will be for one year

Approval Criteria

Initiation of therapy:

- Initial 7 day supply will be authorized automatically when a pharmacy submits a PA Type and Number (To Be Determined)
- An appropriate ICD diagnosis code related to opioid dependence or addiction must be submitted on the claim.
- The Prescriber is responsible for submitting prior authorization request for the member so they may have continued access.
- This override can be used if no PA is on file to initiate or re-initiate therapy for recipients with a gap in treatment.

Prior Authorization Criteria:

- Nevada Medicaid encourages recipients to participate in formal substance abuse counseling and treatment.
- Approval will be given if all of the following criteria are met and documented:
  1. The recipient is 16 years of age or older, and
  2. The recipient has a diagnosis of opioid dependence, and
  3. Requests for a diagnosis of chronic pain will not be approved, and
  4. There is documentation the recipient has honored all of their office visits, and
  5. The medication is being prescribed by a physician with a Drug Addiction Treatment Act (DATA) of 2000 waiver who has a unique “X” DEA number, and
  6. All of the following are met:
     a. The recipient will not utilize opioids, including tramadol, concurrently with the requested agents, and
     b. If the recipient is currently utilizing an opioid, medical documentation must be provided stating the recipient will discontinue the opioid to initiation of buprenorphine or buprenorphine/naloxone
  7. Requests for buprenorphine will be approved if one of the following is met:
     a. The recipient is a pregnant female.
     b. There is documentation that the recipient is breastfeeding an infant who is dependent on methadone or morphine;
     c. The recipient has had an allergy to a buprenorphine/naloxone

d. The recipient has moderate to severe hepatic impairment (Child-Pugh B to C)

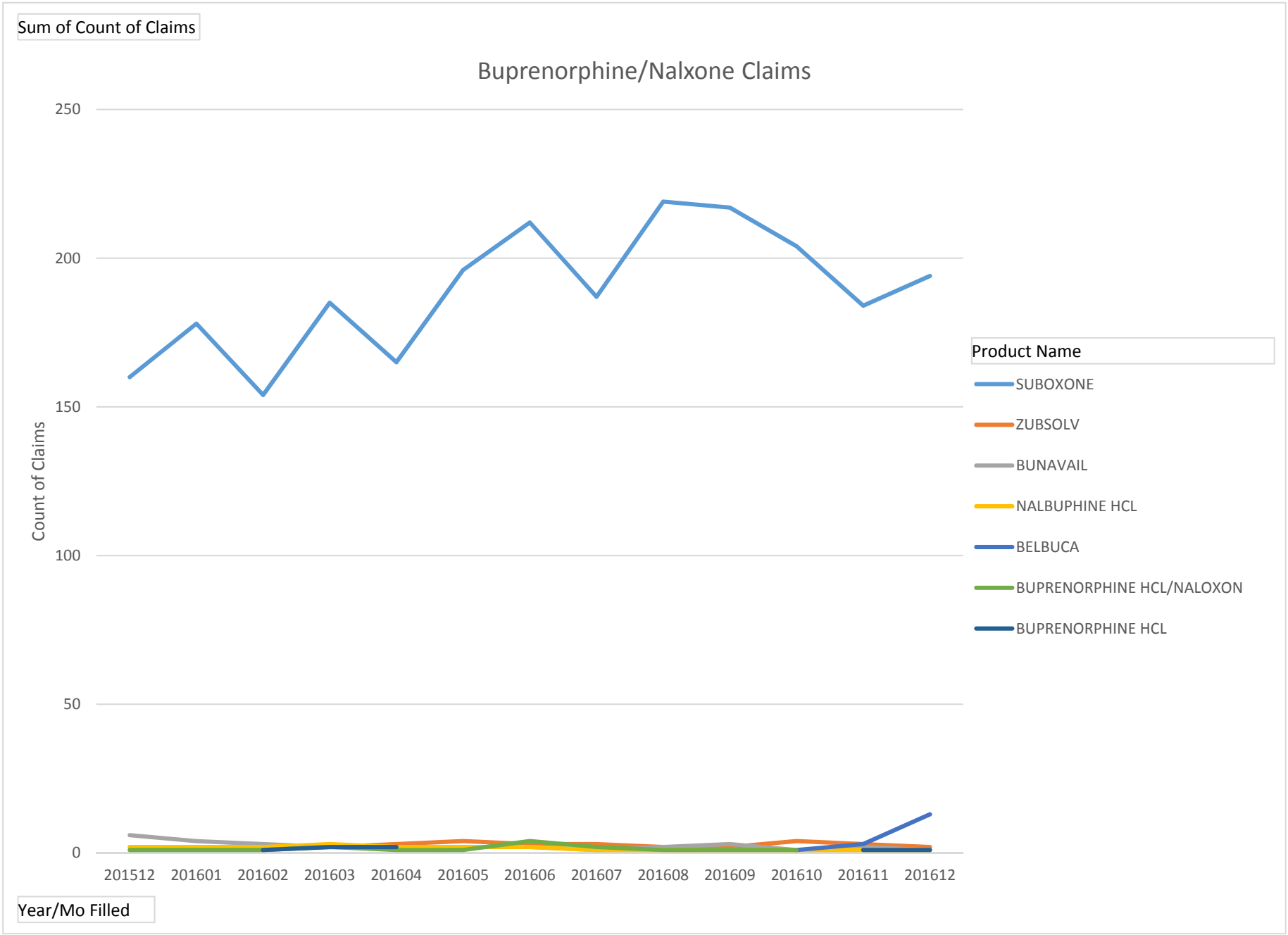
8. Requests that exceed the quantity limit must meet all of the following:
   a. There is documentation in the recipient's medical record that the requested dose is the lowest effective dose for the recipient, and
   b. The treatment plan has been provided.

Quantity Limits

A. buprenorphine sublingual tablets: 3/day
B. buprenorphine/naloxone sublingual film (Suboxone®): 2/day
C. buprenorphine/naloxone sublingual tablet (Zubsolv®): 1/day
D. buprenorphine/naloxone sublingual tablet: 3/day
E. buprenorphine/naloxone buccal film (Bunavail®): 2 units/day

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Qty Total	Sum of Days Supply	Sum of Pharm Paid
BELBUCA	**11**	**18**	**840**	**385**	**$5,105.08**
201608	1	1	60	30	$254.33
201610	1	1	60	30	$258.80
201611	3	3	180	90	$912.55
201612	6	13	540	235	$3,679.40
BUNAVAIL	**27**	**31**	**1270**	**740**	**$15,155.14**
201512	4	6	179	98	$2,487.78
201601	3	4	173	86	$2,386.11
201602	2	3	82	55	$1,160.14
201603	2	2	52	37	$760.90
201604	2	2	105	60	$1,091.72
201605	2	2	105	60	$1,091.72
201606	2	2	105	60	$1,091.72
201607	1	1	38	30	$551.35
201608	2	2	98	60	$992.03
201609	3	3	93	74	$930.99
201610	1	1	60	30	$440.68
201611	2	2	120	60	$1,305.34
201612	1	1	60	30	$864.66
BUPRENORPHINE HCL	**6**	**7**	**203**	**121**	**$369.49**
201602	1	1	10	5	$28.49
201603	1	2	9	18	$30.74
201604	2	2	64	38	$136.98
201611	1	1	60	30	$86.64
201612	1	1	60	30	$86.64
BUPRENORPHINE HCL/NALOXON	**16**	**18**	**852**	**453**	**$3,986.08**
201512	1	1	60	30	$309.19
201601	1	1	60	30	$324.08
201602	1	1	60	30	$321.02
201603	2	2	67	37	$367.36
201604	1	1	60	30	$320.22
201605	1	1	60	30	$308.16
201606	3	4	150	102	$673.24
201607	2	2	120	60	$485.28
201608	1	1	60	30	$242.64
201609	1	1	60	30	$242.64
201610	1	1	60	30	$242.64
201612	1	2	35	14	$149.61

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Qty Total	Sum of Days Supply	Sum of Pharm Paid
SUBOXONE	**1388**	**2455**	**59187**	**40419**	**$448,119.81**
201512	89	160	3927	2606	$28,409.11
201601	105	178	4397	2800	$32,190.21
201602	99	154	4130	2676	$31,035.03
201603	106	185	5048	3330	$38,053.94
201604	104	165	4033	2668	$30,414.66
201605	111	196	4460	2980	$33,720.47
201606	119	212	4753	3406	$35,906.99
201607	106	187	4521	3125	$34,298.46
201608	124	219	4982	3649	$37,639.39
201609	113	217	4859	3476	$37,314.65
201610	107	204	4742	3367	$36,331.37
201611	102	184	4516	3080	$34,807.03
201612	103	194	4819	3256	$37,998.50
ZUBSOLV	**29**	**32**	**1898**	**729**	**$17,351.92**
201601	1	2	60	30	$428.22
201602	2	2	120	45	$1,091.48
201603	2	2	85	40	$627.07
201604	3	3	163	60	$1,562.37
201605	4	4	192	73	$1,561.38
201606	3	3	168	64	$1,229.69
201607	3	3	210	77	$1,851.36
201608	2	2	150	50	$1,412.91
201609	2	2	150	50	$1,412.91
201610	3	4	240	90	$2,290.25
201611	2	3	210	90	$2,273.74
201612	2	2	150	60	$1,610.54
Grand Total	**1477**	**2561**	**64250**	**42847**	**$490,087.52**


Sum of Count of Claims
Buprenorphine/Nalxone Claims
250
200
150
100
50
0
Count of Claims
201512
201601
201602
201603
201604
201605
201606
201607
201608
201609
201610
201611
201612
Year/Mo Filled
Product Name
SUBOXONE
ZUBSOLV
BUNAVAIL
NALBUPHINE HCL
BELBUCA
BUPRENORPHINE HCL/NALOXON
BUPRENORPHINE HCL

BB. Buprenorphine/Naloxone (Suboxone®/Subutex®)

Therapeutic Class: Narcotic Withdrawal Therapy Agents
Last Reviewed by the DUR Board: April 28, 2016

Buprenorphine/Naloxone (Brand Suboxone®) and Buprenorphine (Brand Subutex®) 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.

1. Coverage and Limitations

Nevada Medicaid encourages recipients to participate in formal substance abuse counseling and treatment.

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

a. The recipient is 16 years of age or older; and

b. The recipient has a diagnosis of opioid dependence; and

c. Requests for a diagnosis of chronic pain will not be approved; and

d. There is documentation the recipient has honored all of their office visits; and

e. The medication is being prescribed by a physician with a Drug Addiction Treatment Act (DATA) of 2000 waiver who has a unique "X" DEA number; and

f. All of the following are met:

1. The recipient will not utilize opioids, including tramadol, concurrently with the requested agent; and

2. If the recipient is currently utilizing an opioid, medical documentation must be provided stating the recipient will discontinue the opioid to initiation of buprenorphine or buprenorphine/naloxone.

g. Requests for buprenorphine will be approved if one of the following is met:

1. The recipient is a pregnant female;

2. There is documentation that the recipient is breastfeeding an infant who is dependent on methadone or morphine;

3. The recipient has had an allergy to a buprenorphine/naloxone; or

4. The recipient has moderate to severe hepatic impairment (Child-Pugh B to C).

h. Requests that exceed the quantity limit must meet all of the following:

1. There is documentation in the recipient's medical record that the requested dose is the lowest effective dose for the recipient; and

2. The treatment plan has been provided.

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

Therapeutic Class Overview
Opioid Partial Agonist for Management of Opioid Dependence - Buprenorphine

INTRODUCTION

- The American Psychiatric Association (APA) defines opioid dependence as a syndrome characterized by a problematic pattern of opioid use, leading to clinically significant impairment or distress (American Psychiatric Association, 2013).
    - Opioid dependence affects about 4.5 million people in the United States and leads to approximately 17,000 deaths annually (Substance Abuse and Mental Health Services Administration, 2012; Substance Abuse and Mental Health Services Administration, 2014).
- Methadone, buprenorphine (with or without naloxone), and naltrexone are Food and Drug Administration (FDA)-approved for the detoxification and maintenance treatment of opioid dependence (Micromedex® 2.0, 2016).
    - Methadone products, when used for the treatment of opioid addiction in detoxification or maintenance programs, may be dispensed only by opioid treatment programs (and agencies, practitioners or institutions by formal agreement with the program sponsor) certified by the Substance Abuse and Mental Health Services Administration and approved by the designated state authority. Certified treatment programs may dispense and use methadone in oral form only and according to the treatment requirements stipulated in the Federal Opioid Treatment Standards (Code of Federal Regulations, Title 42, Sec 8).
    - The Drug Addiction Treatment Act of 2000 (DATA 2000) expanded the clinical context of medication-assisted opioid addiction treatment by allowing qualified physicians to dispense or prescribe specifically approved medications, like buprenorphine, for the treatment of opioid addiction in treatment settings other than the traditional Opioid Treatment Program. In addition, DATA reduced the regulatory burden on physicians who choose to practice opioid addiction therapy by permitting qualified physicians to apply for and receive waivers of the special registration requirements defined in the Controlled Substances Act (Center for Substance Abuse Treatment, 2004).
- All buprenorphine products are Schedule III controlled substances (Drugs@FDA, 2016).
- In 2012, Reckitt Benckiser Pharmaceuticals, Inc. notified the FDA that they were voluntarily discontinuing production of SUBOXONE® (buprenorphine/naloxone) sublingual tablets as a result of increasing concerns over accidental/unsupervised pediatric exposure with the tablets compared to the film formulation. The unique child-resistant, unit-dose packaging of the film formulation is believed to be a contributing factor to reduce exposure rates in children. Distribution of brand SUBOXONE (buprenorphine/naloxone) sublingual tablets was discontinued in March 2013; however, generic formulations remain available.
- Included in this review are the buprenorphine products that are FDA-approved to be used in the induction and maintenance treatment of opioid dependence.
- Medispan Class: Opioid Partial Agonists

Table 1. Medications Included Within Class Review

Drug	Manufacturer	FDA Approval Date	Generic Availability
Single Entity Agents			
SUBUTEX (buprenorphine)* sublingual tablet	Various	10/08/2002	✔
Combination Products			
BUNAVAIL™ (buprenorphine/naloxone) buccal film	Biodelivery Sciences	06/06/2014	-
SUBOXONE‡ (buprenorphine/naloxone) sublingual tablets	Various	10/08/2002	✔
SUBOXONE (buprenorphine/naloxone) sublingual film	Indivior	08/30/2010	-
ZUBSOLV® (buprenorphine/naloxone) sublingual tablets	Orexo US	07/03/2013	-

*SUBUTEX was discontinued; however, generic formulations are available.
‡SUBOXONE tablets were discontinued; however, generic formulations are available and brand name SUBOXONE is available as a film.

(Drugs@FDA, 2016; Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, 2016)

INDICATIONS

Table 2. Food and Drug Administration Approved Indications

Indication	Single Entity Agent	Combination Products			
	SUBUTEX (buprenorphine) sublingual tablets	BUNAVAIL (buprenorphine/ naloxone) film	SUBOXONE (buprenorphine/ naloxone) sublingual tablets	SUBOXONE (buprenorphine/ naloxone) film	ZUBSOLV (buprenorphine/ naloxone) sublingual tablets
Treatment of opioid dependence				✔	✔
Treatment of opioid dependence and is preferred for induction	✔				
Maintenance treatment of opioid dependence		✔	✔		

(Prescribing information: buprenorphine sublingual tablets, 2016; buprenorphine/naloxone sublingual tablets, 2016; BUNAVAIL, 2014; SUBOXONE film, 2016; ZUBSOLV, 2015)

Information on indications, mechanism of action, pharmacokinetics, dosing, and safety has been obtained from the prescribing information for the individual products, except where noted otherwise.

CLINICAL EFFICACY SUMMARY

- Clinical trials have demonstrated that buprenorphine/naloxone is practical and safe for use in diverse community treatment settings including primary care offices (Amass et al, 2004; Fiellin et al, 2008).
- Studies have shown that in adult patients with opioid dependence, the percentage of opioid negative urine tests was significantly higher for both buprenorphine and buprenorphine/naloxone compared to placebo, while no significant difference was seen between the two active treatment groups (Daulouede et al, 2010; Fudala et al, 2003). In addition, a small randomized controlled trial (N=32) also showed no significant difference in withdrawal symptoms between buprenorphine and buprenorphine/naloxone (Strain et al, 2011).
- Several studies have compared the effectiveness of short-term detoxification to medium- or long-term maintenance treatment with buprenorphine monotherapy or buprenorphine/naloxone. Three studies have shown higher treatment retention rate or self-reported drug use with longer treatment duration compared to detoxification; however, one of the studies showed no significant difference in the percentage of positive urine tests between the two treatment groups at 12 weeks (Kakko et al, 2003; Woody et al, 2008; Weiss, 2011).
- In a meta-analysis of 21 randomized controlled trials, patients receiving buprenorphine at doses ≥16 mg/day were more likely to continue treatment compared to patients receiving doses <16 mg/day; however, no significant difference was seen in the percentage of opioid positive urine tests between the high and low dose groups (Fareed et al, 2012[b]).
- Studies that compared different dosing regimens of buprenorphine showed no difference in rate of treatment retention, percentage of urine tests positive for opioids, or withdrawal symptoms (Bickel, et al, 1999; Gibson, et al 2008; Petry et al 1999; Schottenfeld et al, 2000).
- One study found that buprenorphine/naloxone sublingual film was comparable to the sublingual tablet form in dose equivalence and clinical outcomes (Lintzeris et al, 2013).
- Approval of BUNAVAIL (buprenorphine/naloxone) buccal film was based on results of a 12-week, Phase 3 study in 249 patients who were converted from SUBOXONE sublingual tablet or film to BUNAVAIL. The majority of patients who participated found BUNAVAIL easy to use and pleasant in taste. Additionally, there was some resolution in constipation complaints experienced with SUBOXONE (Biodelivery Sciences press release, 2014; Sullivan et al, 2014; Sullivan et al, 2015).
- Buprenorphine has been compared to methadone in several clinical studies and reviewed in multiple meta-analyses. Overall, studies have demonstrated that buprenorphine-based therapy was as effective as methadone in the management of opioid dependence (Farre et al, 2002; Gibson, et al, 2008; Gowing et al, 2009; Johnson et al,

1992; Kamien et al, 2008; Meader et al, 2010; Minnozi et al, 2013; Perry et al, 2013; Petitjean et al, 2001; Soyka et al, 2008; Strain et al, 2011). However, when low doses of buprenorphine were studied (≤8 mg/day), high doses of methadone (≥50 mg/day) proved to be more efficacious (Farre et al, 2002; Ling et al, 1996; Mattick et al, 2014; Schottenfeld et al, 1997).

- A double-blind, 12-week randomized clinical trial was conducted in an outpatient research clinic in 70 adult patients with prescription opioid dependence and positive urine samples that were willing to undergo detoxification. The trial evaluated the relative efficacy of varying buprenorphine tapering regimens (one, two, and four weeks) and subsequent naltrexone maintenance in prescription opioid dependent patients who had been briefly stabilized on combination buprenorphine/naloxone. The main outcomes included the percentage of participants negative for illicit opioid use, retention, naltrexone ingestion, and favorable treatment response (i.e., retained in treatment, opioid abstinent, and receiving naltrexone at the end of the study). The study was conducted in two phases: phase 1 included weeks 1 to 5 (after randomization) and daily clinic visits while phase 2 included weeks 6 to 12 and thrice weekly clinic visits. In both phase 1 and 2, the 4-week taper resulted in greater opioid abstinence than the shorter tapers (P=0.02 and P=0.03, respectively). Additionally, the 4-week taper resulted in more treatment responders (P=0.03) and greater retention and naltrexone use than the shorter tapers (both P=0.04). According to the authors, the results suggest that a subset of prescription opioid-dependent outpatients may respond positively to a 4-week taper plus naltrexone maintenance intervention (Sigmon et al, 2013).
- An open-label, single-site, 14-week randomized clinical trial enrolled 113 patients with prescription opioid dependence to determine the efficacy of buprenorphine taper compared to ongoing maintenance therapy in primary care-based treatment of patients with prescription opioid dependence. The study included a two week induction and stabilization period, 14 weeks of treatment, and two weeks of continuing clinical care. Patients were randomized to buprenorphine taper (taper condition) or ongoing buprenorphine maintenance therapy (maintenance condition). The buprenorphine taper was initiated after 6 weeks of stabilization, lasted for 3 weeks, and included medications for opioid withdrawal, after which patients were offered naltrexone treatment. The maintenance group received ongoing buprenorphine therapy. All patients received physician and nurse support and drug counseling. The primary outcome measures were the overall percentage of opioid-negative urine samples, patient-reported days per week of illicit opioid use, and patient reported maximum consecutive weeks of abstinence from illicit opioids. Secondary outcomes included the percentage of patients meeting criteria for protective transfer and treatment retention (number of days from randomization to last clinical contact). During the trial, the mean percentage of urine samples negative for opioids was lower for patients in the taper group (35.2%; [95% CI, 26.2 to 44.2%]) compared with those in the maintenance group (53.2%; [95% CI, 44.3 to 62%]). Patients in the taper group (n=57) reported more days per week of illicit opioid use than those in the maintenance group (n=56) once they were no longer receiving buprenorphine (mean use, 1.27 [95% CI, 0.6 to 1.94] vs 0.47 [95% CI, 0.19 to 0.74] days). Patients in the taper group had fewer maximum consecutive weeks of opioid abstinence compared with those in the maintenance group (mean abstinence, 2.7 [95% CI, 1.72 to 3.75] vs 5.2 [95% CI, 4.16 to 6.2] weeks). Patients in the taper group were less likely to complete the trial (6 of 57 [11%] vs 37 of 56 [66%]; P<0.001). Sixteen patients in the taper group reinitiated buprenorphine treatment after the taper owing to relapse. The authors concluded that tapering is less efficacious than ongoing maintenance treatment in patients with prescription opioid dependence (Fiellin et al, 2014).
- The American Psychiatric Association, American Society of Addiction Medicine, United States Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, and the Veterans Health Administration publish guidelines for the treatment of opioid dependence. These guidelines support the access of pharmacological therapy for the management of opioid dependence without preference of one agent over another. However, they do suggest that combination buprenorphine products should be used for maintenance treatment (Center for Substance Abuse Treatment, 2004; Kleber et al, 2006; Kraus et al, 2011; Veterans Health Administration, 2015).

SAFETY SUMMARY

- These products are contraindicated in patients with known hypersensitivity to the active ingredients.
- Warnings and precautions include abuse potential, central nervous system depression, dependence, impairment in operating heavy machinery, orthostatic hypotension, neonatal withdrawal, respiratory depression, precipitation of opiate withdrawal, and hepatic impairment.
- Similar to other opiate products, these products may increase intracholedochal pressure, increase cerebrospinal fluid pressure, and obscure diagnosis or exacerbate acute abdominal symptoms.
- These products should not be used as analgesics.

- The most common adverse reactions observed with buprenorphine and buprenorphine/naloxone products include headache, insomnia, nausea, pain, sweating, and withdrawal syndrome.
- All of the buprenorphine-containing products have an associated risk evaluation and mitigation strategy (REMS) program (REMS@FDA, 2016).

(Micromedex 2.0, 2016)

DOSING AND ADMINISTRATION

Table 2a. Dosing and Administration

Drug	Dosage Form: Strength	Usual Recommended Dose	Other Dosing Considerations	Administration Considerations
Single Entity Agents				
SUBUTEX (buprenorphine)	Sublingual tablet: 2 mg, 8 mg	Opioid dependence: Initial: dose should be individualized based on type and degree of opioid dependence and timing of last use; titrate rapidly to clinically effective dose; buprenorphine plus naloxone replace buprenorphine typically after 2 days; Maintenance: (for patients who cannot tolerate naloxone) typical range is 4 to 24 mg daily; adjust dosage in 2 or 4 mg increments/ decrements to level that holds patient in treatment and suppresses opioid withdrawal effects	To avoid precipitating withdrawal, induction should be undertaken when objective and clear signs of withdrawal are evident.	Buprenorphine sublingual tablets should be placed under the tongue until dissolved. For doses requiring the use of more than two tablets, patients are advised to either place all the tablets at once or alternatively, place two tablets at a time under the tongue.
Combination Products				
BUNAVAIL, SUBOXONE, ZUBSOLV (buprenorphine/ naloxone)	Buccal film (BUNAVAIL): 2.1 mg/0.3 mg 4.2 mg/0.7 mg 6.3 mg/1 mg Sublingual film (SUBOXONE): 2 mg/0.5 mg 4 mg/1 mg 8 mg/2 mg 12 mg/3 mg Sublingual tablet (generics, ZUBSOLV): 2 mg/0.5 mg* 8 mg/2 mg* 1.4 mg/0.36 mg† 2.9 mg/0.71mg†	Opioid dependence: Buccal film (BUNAVAIL): Maintenance; the recommended dose is 8.4 mg/1.4 mg buprenorphine/ naloxone per day administered as a single dose (range 2.1 mg/0.3 mg to 12.6 mg/2.1 mg) Sublingual film (SUBOXONE): Induction; up to 8 mg/2 mg is recommended on Day 1, given as an initial dose of 2 mg/0.5 mg or 4 mg/1 mg and		Buprenorphine/ naloxone sublingual tablets should be placed under the tongue until dissolved. For doses requiring the use of more than two SUBOXONE tablets, patients are advised to either place all the tablets at once or alternatively, place two tablets at a time under the tongue. Patients requiring more than one ZUBSOLV tablet are advised

Drug	Dosage Form: Strength	Usual Recommended Dose	Other Dosing Considerations	Administration Considerations
	5.7 mg/1.4 mg† 8.6 mg/2.1 mg† 11.4 mg/2.9 mg†	titrated in 2 mg to 4 mg increments of buprenorphine at approximately 2 hour intervals based on the control of acute symptoms; on Day 2, a single dose of up to 16 mg/4 mg is recommended; Maintenance; recommended dose is 16 mg/4 mg buprenorphine/ naloxone per day administered as a single dose (range 4 mg/1 mg to 24 mg/6 mg) Sublingual tablets (ZUBSOLV): Induction; initial dose of up to 5.7 mg/1.4 mg is recommended, given as an initial dose of 1.4 mg/0.36 mg followed by the remaining Day 1 dose divided into 1 to 2 tablets of 1.4 mg/0.36 mg at 1.5 to 2 hour intervals; on Day 2, a single daily dose of up to 11.4 mg/2.9 mg is recommended; Maintenance; target dose buprenorphine/ naloxone 11.4 mg/2.9 mg once daily; typical dosage range, buprenorphine/ naloxone 2.9 mg/0.71 mg to 17.2 mg/4.2 mg daily Buprenorphine/ naloxone generic sublingual tablets: Maintenance; recommended dose is 16 mg/4 mg buprenorphine/ naloxone per day administered as a		to place all tablets in different places under the tongue at the same time. Do not crush, break, chew, or swallow the tablets. The SUBOXONE sublingual film should be placed under the tongue close to the base on the left or right side (one film only). If more film is needed to achieve the dose, place an additional film under the tongue on the opposite side. Minimize overlap as much as possible. Keep the film under the tongue until completely dissolved. If a third film is needed, put it under the tongue after the first 2 films have dissolved. Do not cut, chew, or swallow the film. For induction, the sublingual route of SUBOXONE film is preferred. For maintenance, SUBOXONE film may be administered buccally or sublingually. For buccal use, one film can be placed on the inside of both the right and left cheeks until completely dissolved. If more than 2 films are needed, place additional film on

Drug	Dosage Form: Strength	Usual Recommended Dose	Other Dosing Considerations	Administration Considerations
		single dose; range 4 mg/1 mg to 24 mg/6 mg daily		the inside of the cheek after the first 2 films have dissolved. The BUNAVAIL buccal film should be applied to the buccal mucosa (with the text on the film against the side of the cheek). Press and hold in place for five seconds and leave in place until dissolved; do not eat or drink until dissolved. Two films may be applied at once (one to each cheek). No more than two films should be applied to the inside of one cheek at a time. Do not cut or tear film. Taper therapy to avoid withdrawal symptoms.

*Generic buprenorphine/naloxone sublingual tablets.
†ZUBSOLV (buprenorphine/naloxone) sublingual tablets.

Table 2b. Equivalent Doses of Buprenorphine/Naloxone Combination Products[a]

BUNAVAIL buccal film	buprenorphine/naloxone sublingual tablets and/or SUBOXONE sublingual film	ZUBSOLV sublingual tablets
-	2 mg/0.5 mg	1.4 mg/0.36 mg
2.1 mg/ 0.3 mg	4 mg/1 mg	2.9 mg/0.71 mg
4.2 mg/ 0.7 mg	8 mg/2 mg	5.7 mg/1.4 mg
6.3 mg/1 mg	12 mg/3 mg	8.6 mg/2.1 mg
-	16 mg/4 mg	11.4 mg/2.9 mg

[a] Systemic exposures of buprenorphine and naloxone may differ when patients are switched from tablets to films or vice versa.

(Micromedex 2.0, 2016)

SPECIAL POPULATIONS

Table 3. Special Populations

Drug	Population and Precaution				
	Elderly	Pediatrics	Renal Dysfunction	Hepatic Dysfunction	Pregnancy and Nursing
Single Entity Agents					
SUBUTEX (buprenorphine)	Clinical studies did not include sufficient number of subjects aged 65 and over to determine whether they responded differently than younger subjects. Dose selection for elderly patients should be cautious, usually starting at the low end of the dosing range.	Safety and efficacy have not been established.	No dosage adjustment required.	Severe hepatic impairment: Consider reducing the starting and titration incremental dose by half and monitor for signs and symptoms of toxicity or overdose. Moderate hepatic impairment: No dose adjustment necessary. Use with caution and monitor for signs and symptoms of toxicity or overdose. Mild hepatic impairment: No dosage adjustment necessary.	Pregnancy Category C* Buprenorphine passes into breast milk. Caution should be exercised and infant monitored for increased drowsiness and breathing difficulties.
Combination Products					
BUNAVAIL, SUBOXONE, ZUBSOLV (buprenorphine/ naloxone)	Clinical studies did not include sufficient number of subjects aged 65 and over to determine whether they responded differently than younger subjects. Dose selection for elderly patients should	Safety and efficacy have not been established.	No dosage adjustment required.	Unknown; because both drugs are extensively metabolized by the liver, plasma levels may be higher in patients with moderate and severe hepatic impairment. Dosage should be adjusted and patients should	Pregnancy Category C* Buprenorphine passes into breast milk. Caution should be exercised and infant monitored for increased drowsiness and breathing difficulties.

Drug	Population and Precaution				
	Elderly	Pediatrics	Renal Dysfunction	Hepatic Dysfunction	Pregnancy and Nursing
	be cautious, usually starting at the low end of the dosing range.			be watched for signs and symptoms for precipitated opioid withdrawal. Since they are fixed dose combinations including naloxone, these formulations should generally be avoided in patients with severe hepatic impairment and may not be appropriate for patients with moderate hepatic impairment.	

*Pregnancy Category C=Risk cannot be ruled out. Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.

(Micromedex 2.0, 2016)

CONCLUSION

- Buprenorphine sublingual tablets, buprenorphine/naloxone sublingual tablets, BUNAVAIL (buprenorphine/naloxone) buccal film, SUBOXONE (buprenorphine/naloxone) sublingual film, and ZUBSOLV (buprenorphine/naloxone) sublingual tablets are used for the treatment of opioid dependence. Some products are indicated for maintenance treatment only, while others are indicated for both induction and maintenance.
- For patients unable to receive methadone-clinic based treatment, buprenorphine and buprenorphine/naloxone remain viable treatment options. Buprenorphine may be used for the earlier stages of therapy when treatment is observed since it does not have the naloxone component to deter inappropriate use. These agents are Schedule III controlled substances.
- Clinical trials have demonstrated that buprenorphine/naloxone is practical and safe for use in diverse community treatment settings including primary care offices (Amass et al, 2004; Fiellin et al, 2008).
- Physicians prescribing buprenorphine for opioid dependency must undergo specialized training due to the potential for abuse and diversion. Because of these risks, buprenorphine monotherapy should be reserved for patients who are pregnant or have a documented allergy to naloxone (DATA, 2000; Center for Substance Abuse Treatment, 2004).
- Overall, studies have demonstrated that buprenorphine-based therapy was as effective as methadone in the management of opioid dependence (Farre et al, 2002; Gibson, et al, 2008; Gowing et al, 2009; Johnson et al, 1992; Kamien et al, 2008; Meader et al, 2010; Petitjean et al, 2001; Soyka et al, 2008; Mattick et al, 2014; Strain et al, 2011).
- The most common adverse reactions observed with buprenorphine and buprenorphine/naloxone products include headache, insomnia, nausea, pain, sweating, and withdrawal syndrome. These products also have REMS criteria.
- The American Psychiatric Association, American Society of Addiction Medicine, United States Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, and the Veterans Health Administration publish guidelines for the treatment of opioid dependence. These guidelines support the access of

pharmacological therapy for the management of opioid dependence without preference of one agent over another. However, they do suggest that combination products should be used for maintenance treatment (Center for Substance Abuse Treatment, 2004; Kleber et al, 2006; Kraus et al, 2011; Veterans Health Administration, 2015).

- Buprenorphine and buprenorphine/naloxone sublingual tablets are available generically.

Table 4. Advantages and Disadvantages of Buprenorphine Products

Drug	Advantages	Disadvantages
Single Entity Agents		
buprenorphine sublingual tablets	Available as a generic; preferred for induction	Does not contain naloxone component to deter abuse; not preferred for maintenance
Combination Products		
BUNAVAIL (buprenorphine/naloxone) buccal film	Contains naloxone to deter abuse	Not available as a generic; indicated for maintenance treatment only
buprenorphine/naloxone sublingual tablets	Contains naloxone to deter abuse; available as a generic	Longer dissolution time compared to films; indicated for maintenance treatment only
SUBOXONE (buprenorphine/naloxone) sublingual film	Contains naloxone to deter abuse; can be used for induction and maintenance; can be administered either sublingually or buccally for maintenance treatment	Not available as a generic
ZUBSOLV (buprenorphine/naloxone) sublingual tablets	Contains naloxone to deter abuse; can be used for induction and maintenance	Not available as a generic

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Therapeutic Class Review updated by: H. Ipema, PharmD, BCPS
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Top 10 Opioid User Detail

December 1, 2015 - December 31, 2016

Encrypted ID	Enc NPI		Product Name	Count of Date of Fill	Sum of Qty	Sum of Days Supply	Sum of Pharm Pd
A		15	HYDROMORPHONE HCL	26	3720	715	$613.31
			OXYCODONE HCL	13	3510	390	$1,396.26
	15 Total			**39**	**7230**	**1105**	**$2,009.57**
A Total				**39**	**7230**	**1105**	**$2,009.57**
B		23	METHADONE HCL	13	6240	390	$925.05
			MORPHINE SULFATE ER	13	1170	390	$2,220.27
	23 Total			**26**	**7410**	**780**	**$3,145.32**
B Total				**26**	**7410**	**780**	**$3,145.32**
C		2	OXYCODONE HCL	1	45	5	$19.49
			SUBSYS	1	120	20	$8,918.53
	2 Total			**2**	**165**	**25**	**$8,938.02**
		6	MORPHINE SULFATE ER	2	120	60	$257.00
			OXYCODONE HCL	13	3480	290	$1,257.43
	6 Total			**15**	**3600**	**350**	**$1,514.43**
		7	FENTANYL	1	10	30	$116.49
			MORPHINE SULFATE ER	2	120	60	$257.00
			OXYCODONE HCL	13	2950	260	$1,046.15
			SUBSYS	1	120	20	$8,918.53
	7 Total			**17**	**3200**	**370**	**$10,338.17**
		13	HYDROCODONE/ACETAMINOPHEN	1	20	4	$13.77

Encrypted ID	Enc NPI	Product Name	Count of Date of Fill	Sum of Qty	Sum of Days Supply	Sum of Pharm Pd
C	**13 Total**		**1**	**20**	**4**	**$13.77**
	14	OXYCODONE HCL	4	960	110	$238.98
	14 Total		**4**	**960**	**110**	**$238.98**
	18	OXYCODONE HCL	1	42	4	$17.77
	18 Total		**1**	**42**	**4**	**$17.77**
C Total			**40**	**7987**	**863**	**$21,061.14**
D	**22**	ENDOCET	1	180	30	$129.16
		MORPHINE SULFATE	13	3119	355	$1,125.97
		MORPHINE SULFATE ER	9	810	270	$3,230.71
		NUCYNTA ER	3	180	90	$3,048.53
		OXYCODONE/ACETAMINOPHEN	12	2160	300	$1,446.65
		TRAMADOL HCL	11	2340	330	$163.20
		TRAMADOL HYDROCHLORIDE/AC	1	120	15	$33.78
	22 Total		**50**	**8909**	**1390**	**$9,178.00**
D Total			**50**	**8909**	**1390**	**$9,178.00**
E	**3**	METHADONE HCL	5	450	150	$107.41
		OXYCODONE HCL	10	2070	300	$828.06
	3 Total		**15**	**2520**	**450**	**$935.47**
	9	METHADONE HCL	3	270	90	$61.91
		OXYCODONE HCL	6	1350	110	$514.69
	9 Total		**9**	**1620**	**200**	**$576.60**

Encrypted ID	Enc NPI	Product Name	Count of Date of Fill	Sum of Qty	Sum of Days Supply	Sum of Pharm Pd
E Total			**24**	**4140**	**650**	**$1,512.07**
F	**4**	ACETAMINOPHEN/CODEINE	19	3420	342	$952.02
		ACETAMINOPHEN/CODEINE #4	4	720	72	$208.88
		BUTALBITAL/ASPIRIN/CAFFEI	9	540	180	$874.22
		HYDROCODONE/IBUPROFEN	15	2700	360	$1,062.63
	4 Total		**47**	**7380**	**954**	**$3,097.75**
F Total			**47**	**7380**	**954**	**$3,097.75**
G	**1**	HYDROCODONE/ACETAMINOPHEN	14	3900	436	$866.42
		METHADONE HCL	14	3780	420	$653.30
	1 Total		**28**	**7680**	**856**	**$1,519.72**
G Total			**28**	**7680**	**856**	**$1,519.72**
H	**10**	OXYCODONE/ACETAMINOPHEN	1	25	6	$25.04
	10 Total		**1**	**25**	**6**	**$25.04**
	12	FENTANYL	2	20	60	$110.83
		HYDROCODONE/ACETAMINOPHEN	3	390	59	$98.95
		MORPHINE SULFATE ER	6	390	180	$293.68
		OXYCODONE HCL	7	1680	192	$615.00
		OXYCODONE/ACETAMINOPHEN	2	420	57	$186.91
		VICODIN HP	2	230	38	$416.16
	12 Total		**22**	**3130**	**586**	**$1,721.53**
	16	HYDROCODONE/ACETAMINOPHEN	1	40	10	$17.69
	16 Total		**1**	**40**	**10**	**$17.69**

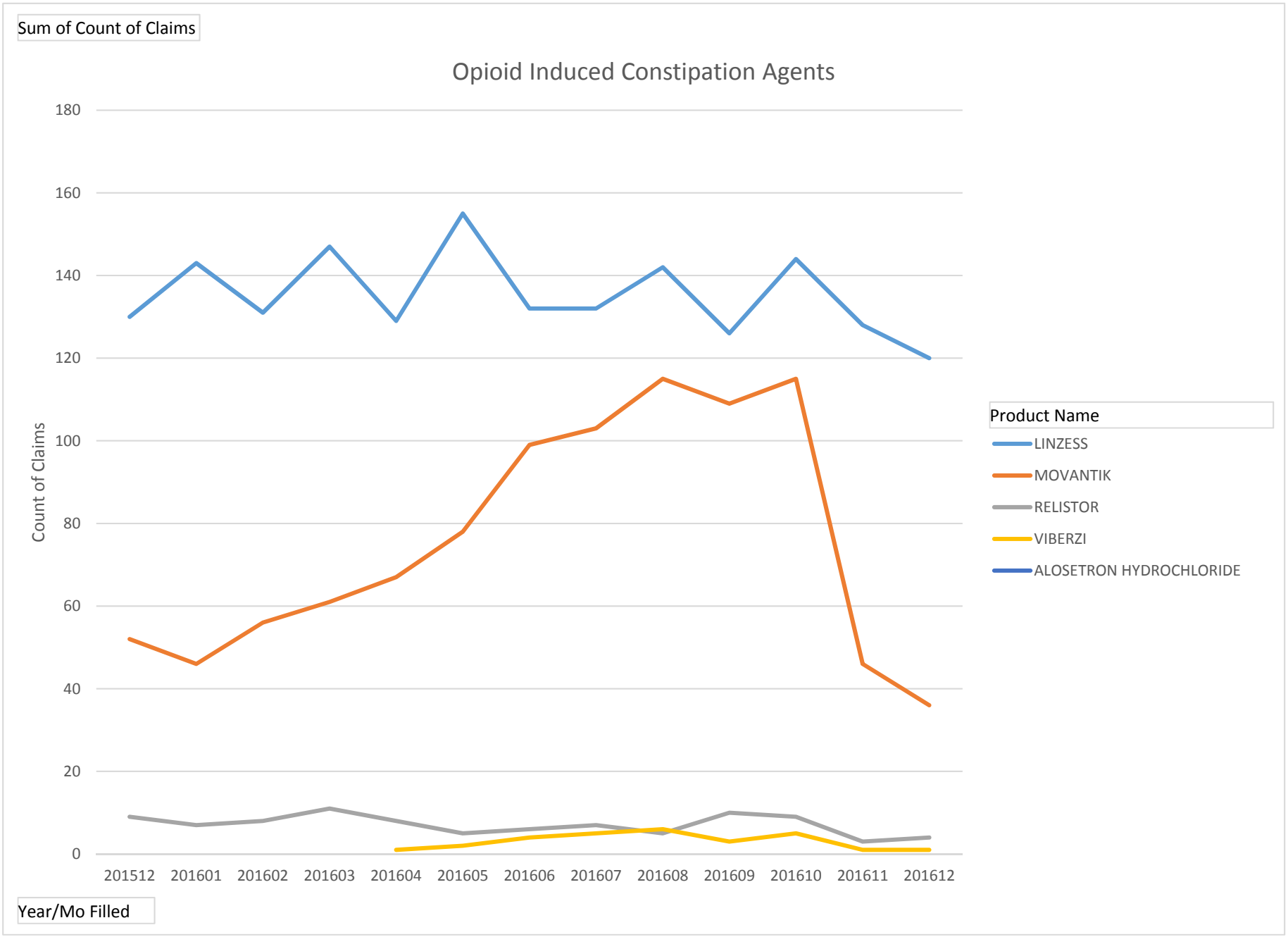
Encrypted ID	Enc NPI	Product Name	Count of Date of Fill	Sum of Qty	Sum of Days Supply	Sum of Pharm Pd
H						
	17	HYDROMORPHONE HCL	1	45	11	$14.01
	17 Total		**1**	**45**	**11**	**$14.01**
	19	HYDROCODONE/ACETAMINOPHEN	2	240	37	$56.52
	19 Total		**2**	**240**	**37**	**$56.52**
	20	HYDROCODONE/ACETAMINOPHEN	1	120	30	$32.14
	20 Total		**1**	**120**	**30**	**$32.14**
H Total			**28**	**3600**	**680**	**$1,866.93**
I	**5**	BUTALBITAL/ACETAMINOPHEN/	4	480	80	$540.90
		METHADONE HCL	6	540	180	$121.49
		OXYCODONE HCL	3	422	75	$112.37
	5 Total		**13**	**1442**	**335**	**$774.76**
	11	BUTALBITAL/ACETAMINOPHEN/	3	360	60	$408.12
		METHADONE HCL	7	540	180	$102.98
		OXYCODONE HCL	5	1200	150	$268.41
	11 Total		**15**	**2100**	**390**	**$779.51**
I Total			**28**	**3542**	**725**	**$1,554.27**
J	**8**	METHADONE HCL	2	2160	60	$287.19
	8 Total		**2**	**2160**	**60**	**$287.19**
	21	HYDROCODONE/ACETAMINOPHEN	1	30	6	$16.06
		METHADONE HCL	12	13680	360	$1,829.14

Encrypted ID	Enc NPI	Product Name	Count of Date of Fill	Sum of Qty	Sum of Days Supply	Sum of Pharm Pd
J	21 Total		13	13710	366	$1,845.20
J Total			15	15870	426	$2,132.39
Grand Total			325	73748	8429	$47,077.16

Opioid Induced Constipation Agents
December 1, 2015 - December 31, 2016

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Qty Total	Sum of Days Supply	Sum of Pharm Paid
ALOSETRON HYDROCHLORIDE	**1**	**1**	**60**	**30**	**$1,924.51**
201602	1	1	60	30	$1,924.51
LINZESS	**1647**	**1759**	**54114**	**52530**	**$569,962.94**
201512	118	130	3864	3864	$39,250.14
201601	131	143	4390	4267	$44,550.79
201602	126	131	4020	3907	$40,797.32
201603	136	147	4560	4370	$46,255.52
201604	126	129	4011	3848	$41,977.67
201605	140	155	4879	4643	$52,332.21
201606	127	132	4131	3955	$44,322.19
201607	127	132	4069	3934	$43,684.34
201608	131	142	4425	4252	$47,484.01
201609	115	126	3840	3765	$41,245.72
201610	134	144	4350	4320	$46,727.72
201611	122	128	3854	3804	$41,399.08
201612	114	120	3721	3601	$39,936.23
MOVANTIK	**937**	**983**	**29685**	**29190**	**$276,515.72**
201512	49	52	1590	1560	$13,302.11
201601	46	46	1430	1370	$12,575.48
201602	53	56	1770	1650	$16,195.95
201603	56	61	1875	1785	$17,173.70
201604	66	67	2020	1990	$18,515.53
201605	76	78	2370	2340	$21,717.39
201606	90	99	2925	2895	$26,831.07
201607	100	103	3120	3075	$29,255.41
201608	109	115	3465	3420	$33,290.97
201609	104	109	3255	3240	$31,283.75
201610	112	115	3425	3425	$32,920.95
201611	45	46	1360	1360	$13,075.29
201612	31	36	1080	1080	$10,378.12
RELISTOR	**88**	**92**	**1252.8**	**2424**	**$132,935.26**
201512	7	9	73.2	243	$11,970.50
201601	7	7	59.4	158	$9,758.04
201602	8	8	77.4	218	$12,006.26
201603	11	11	130.2	301	$21,290.85
201604	7	8	90.6	215	$14,960.32
201605	5	5	50.4	148	$8,229.81
201606	6	6	68.4	176	$11,161.04

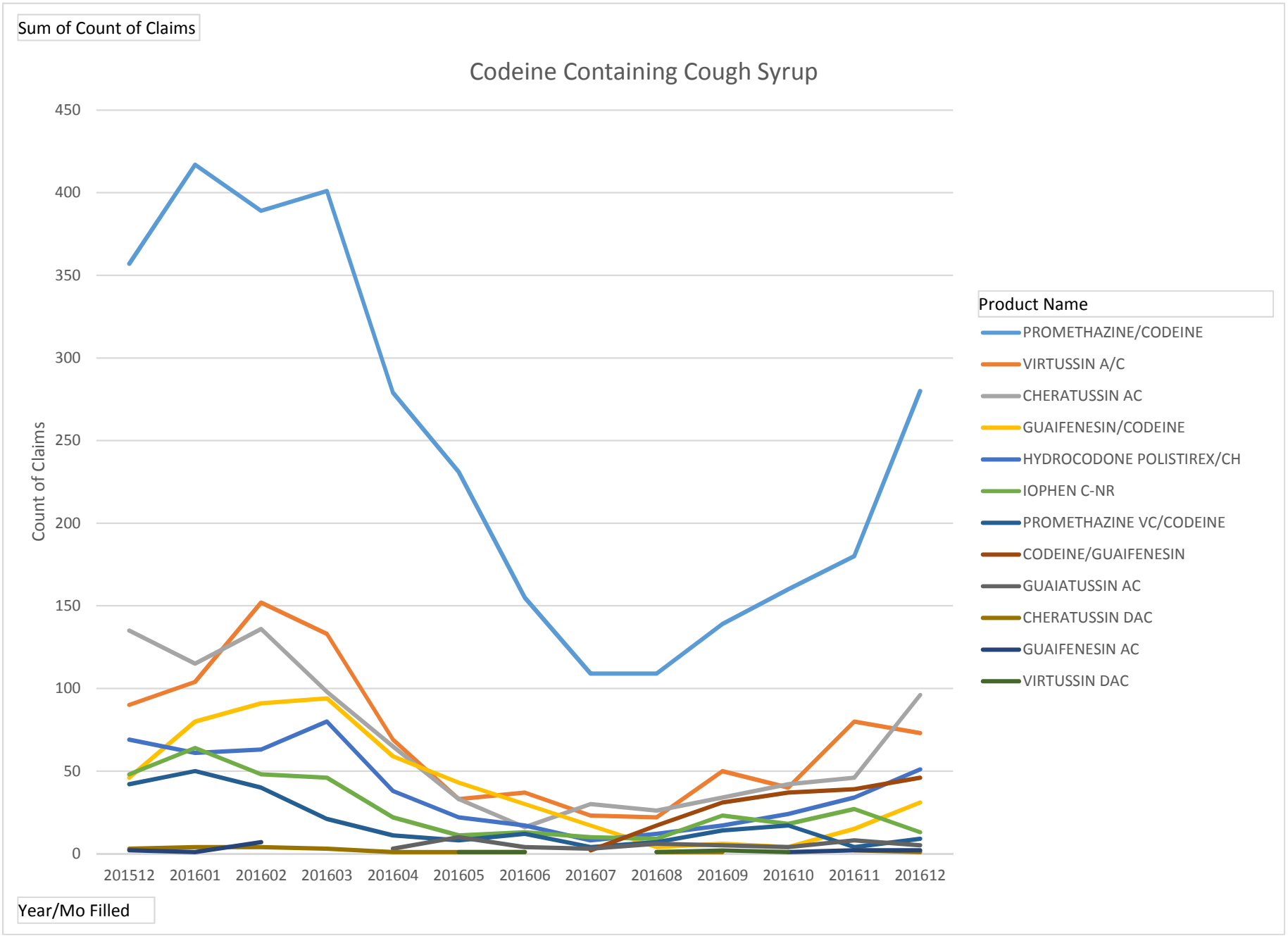
Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Qty Total	Sum of Days Supply	Sum of Pharm Paid
201607	7	7	58.8	160	$8,951.04
201608	5	5	37.8	125	$6,071.02
201609	10	10	77.4	254	$12,442.47
201610	8	9	66.6	216	$6,468.08
201611	3	3	184.2	90	$3,715.39
201612	4	4	278.4	120	$5,910.44
VIBERZI	**28**	**28**	**1650**	**840**	**$25,837.84**
201604	1	1	60	30	$944.73
201605	2	2	120	60	$1,878.24
201606	4	4	210	120	$3,292.01
201607	5	5	300	150	$4,695.60
201608	6	6	360	180	$5,634.72
201609	3	3	180	90	$2,817.36
201610	5	5	300	150	$4,697.55
201611	1	1	60	30	$939.12
201612	1	1	60	30	$938.51
Grand Total	**2701**	**2863**	**86761.8**	**85014**	**$1,007,176.27**


Sum of Count of Claims
Opioid Induced Constipation Agents
180
160
140
120
100
80
60
40
20
0
Count of Claims
201512
201601
201602
201603
201604
201605
201606
201607
201608
201609
201610
201611
201612
Year/Mo Filled
Product Name
LINZESS
MOVANTIK
RELISTOR
VIBERZI
ALOSETRON HYDROCHLORIDE

Codeine Containing Cough Suppressants

January 1, 2016 - December 31, 2016

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Qty Total	Sum of Days Supply	Sum of Pharm Paid	Sum of Calc Qty/Clm	Sum of Days/Member
CHERATUSSIN AC	848	872	153,285	7,255	$14,454.45	176	9
CHERATUSSIN DAC	22	22	4,964	195	$911.22	226	9
CODEINE/GUAIFENESIN	165	172	29,011	1,815	$2,540.15	169	11
GUAIATUSSIN AC	49	49	11,625	420	$906.08	237	9
GUAIFENESIN AC	15	16	2,190	132	$241.90	137	9
GUAIFENESIN/CODEINE	499	520	90,338	4,273	$8,341.30	174	9
HYDROCODONE POLISTIREX/CH	475	496	51,176	5,712	$27,579.18	103	12
IOPHEN C-NR	341	352	64,370	2,625	$5,920.30	183	8
PROMETHAZINE VC/CODEINE	216	239	26,288	1,632	$10,453.21	110	8
PROMETHAZINE/CODEINE	2,848	3,206	355,023	20,566	$36,899.61	111	7
VIRTUSSIN A/C	891	906	150,314	7,109	$15,007.98	166	8
VIRTUSSIN DAC	14	15	2,490	132	$577.47	166	9
Grand Total	**6383**	**6865**	**941073.874**	**51866**	**$123,832.85**	**137**	**8**


Sum of Count of Claims
Codeine Containing Cough Syrup
450
400
350
300
250
200
150
100
50
0
Count of Claims
201512
201601
201602
201603
201604
201605
201606
201607
201608
201609
201610
201611
201612
Year/Mo Filled
Product Name
PROMETHAZINE/CODEINE
VIRTUSSIN A/C
CHERATUSSIN AC
GUAIFENESIN/CODEINE
HYDROCODONE POLISTIREX/CH
IOPHEN C-NR
PROMETHAZINE VC/CODEINE
CODEINE/GUAIFENESIN
GUAIATUSSIN AC
CHERATUSSIN DAC
GUAIFENESIN AC
VIRTUSSIN DAC

Top 10 Drug Group by Paid Amt

Q2 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
85	HEMATOLOGICAL AGENTS - MISC.*	3,970	$ 9,497,316.28
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	30,573	$ 8,642,955.08
12	ANTIVIRALS*	4,621	$ 8,447,604.50
27	ANTIDIABETICS*	29,216	$ 4,509,734.45
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	42,939	$ 4,448,011.15
72	ANTICONVULSANTS*	45,833	$ 3,494,343.07
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	3,908	$ 3,471,390.82
30	ENDOCRINE AND METABOLIC AGENTS - MISC.*	4,096	$ 2,518,757.46
65	ANALGESICS - OPIOID*	63,977	$ 2,340,525.75
61	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREX	10,463	$ 2,191,365.76

Q3 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	30,552	$ 8,866,116.41
85	HEMATOLOGICAL AGENTS - MISC.*	3,702	$ 8,454,118.82
12	ANTIVIRALS*	4,164	$ 7,812,360.33
27	ANTIDIABETICS*	28,313	$ 4,664,093.33
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	4,271	$ 4,243,474.24
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	40,411	$ 4,218,066.23
72	ANTICONVULSANTS*	45,497	$ 3,680,634.15
30	ENDOCRINE AND METABOLIC AGENTS - MISC.*	3,996	$ 2,671,373.75
62	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT	4,990	$ 2,272,638.36
65	ANALGESICS - OPIOID*	62,601	$ 2,234,328.62

Q4 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	30,552	$ 8,866,116.41
85	HEMATOLOGICAL AGENTS - MISC.*	3,702	$ 8,454,118.82
12	ANTIVIRALS*	4,164	$ 7,812,360.33
27	ANTIDIABETICS*	28,313	$ 4,664,093.33
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	4,271	$ 4,243,474.24
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	40,411	$ 4,218,066.23
72	ANTICONVULSANTS*	45,497	$ 3,680,634.15
30	ENDOCRINE AND METABOLIC AGENTS - MISC.*	3,996	$ 2,671,373.75
62	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT	4,990	$ 2,272,638.36
65	ANALGESICS - OPIOID*	62,601	$ 2,234,328.62

Top 10 Drug Group by Claim Count

Q2 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
65	ANALGESICS - OPIOID*	63,977	$ 2,340,525.75
72	ANTICONVULSANTS*	45,833	$ 3,494,343.07
58	ANTIDEPRESSANTS*	44,834	$ 865,277.92
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	42,939	$ 4,448,011.15
36	ANTIHYPERTENSIVES*	36,743	$ 462,472.16
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	30,573	$ 8,642,955.08
27	ANTIDIABETICS*	29,216	$ 4,509,734.45
39	ANTIHYPERLIPIDEMICS*	28,413	$ 846,948.15
57	ANTIANXIETY AGENTS*	26,447	$ 291,807.39
66	ANALGESICS - ANTI-INFLAMMATORY*	25,907	$ 1,645,980.08

Q3 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
65	ANALGESICS - OPIOID*	62,601	$ 2,234,328.62
72	ANTICONVULSANTS*	45,497	$ 3,680,634.15
58	ANTIDEPRESSANTS*	45,076	$ 868,175.76
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	40,411	$ 4,218,066.23
36	ANTIHYPERTENSIVES*	36,018	$ 482,511.34
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	30,552	$ 8,866,116.41
27	ANTIDIABETICS*	28,313	$ 4,664,093.33
39	ANTIHYPERLIPIDEMICS*	27,580	$ 815,346.12
57	ANTIANXIETY AGENTS*	26,407	$ 295,554.55
49	ULCER DRUGS*	25,729	$ 1,248,026.99

Q4 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
65	ANALGESICS - OPIOID*	56,599	$ 2,051,814.21
58	ANTIDEPRESSANTS*	43,569	$ 844,724.12
72	ANTICONVULSANTS*	43,293	$ 3,612,420.84
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	41,376	$ 4,323,625.98
36	ANTIHYPERTENSIVES*	33,634	$ 474,958.24
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	29,443	$ 8,542,669.89
27	ANTIDIABETICS*	25,956	$ 4,562,842.00
39	ANTIHYPERLIPIDEMICS*	25,544	$ 750,890.68
57	ANTIANXIETY AGENTS*	24,325	$ 283,154.70
66	ANALGESICS - ANTI-INFLAMMATORY*	24,105	$ 1,716,848.76

Top 10 Drug Classes by Paid Amt

Q2 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
8510	ANTIHEMOPHILIC PRODUCTS**	99	$ 9,008,974.49
1235	HEPATITIS AGENTS**	342	$ 5,084,281.21
5925	QUINOLINONE DERIVATIVES**	4,573	$ 4,001,103.93
1210	ANTIRETROVIRALS**	2,497	$ 3,227,888.06
2710	INSULIN**	9,234	$ 3,056,550.88
4420	SYMPATHOMIMETICS**	28,418	$ 2,787,047.21
7260	ANTICONVULSANTS - MISC.**	33,351	$ 2,383,324.38
5907	BENZISOXAZOLES**	7,411	$ 1,918,837.07
6240	MULTIPLE SCLEROSIS AGENTS**	330	$ 1,616,694.40
5940	ANTIPSYCHOTICS - MISC.**	3,027	$ 1,335,640.83

Q3 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
8510	ANTIHEMOPHILIC PRODUCTS**	88	$ 8,076,744.35
1235	HEPATITIS AGENTS**	308	$ 4,568,255.48
5925	QUINOLINONE DERIVATIVES**	4,406	$ 3,992,993.36
1210	ANTIRETROVIRALS**	2,328	$ 3,174,676.62
2710	INSULIN**	8,858	$ 3,144,114.67
4420	SYMPATHOMIMETICS**	26,952	$ 2,698,618.41
7260	ANTICONVULSANTS - MISC.**	33,362	$ 2,492,868.96
5907	BENZISOXAZOLES**	7,324	$ 2,134,646.60
6240	MULTIPLE SCLEROSIS AGENTS**	373	$ 1,799,241.23
5940	ANTIPSYCHOTICS - MISC.**	3,044	$ 1,419,696.63

Q4 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
8510	ANTIHEMOPHILIC PRODUCTS**	94	$ 8,922,391.95
1235	HEPATITIS AGENTS**	297	$ 4,317,718.35
5925	QUINOLINONE DERIVATIVES**	4,496	$ 3,935,124.04
1210	ANTIRETROVIRALS**	2,219	$ 3,092,747.28
2710	INSULIN**	8,116	$ 3,045,841.66
4420	SYMPATHOMIMETICS**	28,338	$ 2,792,919.73
7260	ANTICONVULSANTS - MISC.**	31,667	$ 2,447,446.65
5907	BENZISOXAZOLES**	6,963	$ 2,020,701.71
6240	MULTIPLE SCLEROSIS AGENTS**	379	$ 1,591,092.89
5940	ANTIPSYCHOTICS - MISC.**	2,789	$ 1,383,181.37

Top 10 Drug Classes by Claim Count

Q2 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
6599	OPIOID COMBINATIONS**	36,031	$ 998,619.78
7260	ANTICONVULSANTS - MISC.**	33,351	$ 2,383,324.38
4420	SYMPATHOMIMETICS**	28,418	$ 2,787,047.21
6510	OPIOID AGONISTS**	27,084	$ 1,189,543.00
6610	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*	25,434	$ 324,302.91
3940	HMG COA REDUCTASE INHIBITORS**	23,247	$ 451,276.52
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**	22,291	$ 270,261.54
5710	BENZODIAZEPINES**	19,589	$ 194,569.28
7510	CENTRAL MUSCLE RELAXANTS**	16,282	$ 313,046.01
3610	ACE INHIBITORS**	16,266	$ 144,716.12

Q3 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
6599	OPIOID COMBINATIONS**	35,062	$ 941,484.91
7260	ANTICONVULSANTS - MISC.**	33,362	$ 2,492,868.96
4420	SYMPATHOMIMETICS**	26,952	$ 2,698,618.41
6510	OPIOID AGONISTS**	26,555	$ 1,132,091.18
6610	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*	24,658	$ 267,791.59
3940	HMG COA REDUCTASE INHIBITORS**	22,704	$ 436,188.00
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**	22,223	$ 275,751.75
5710	BENZODIAZEPINES**	19,312	$ 193,330.77
7510	CENTRAL MUSCLE RELAXANTS**	16,436	$ 311,663.31
3610	ACE INHIBITORS**	15,687	$ 148,005.42

Q4 2016

Class	Drug Class Name	Count of Claims	Pharmacy Paid
6599	OPIOID COMBINATIONS**	31,931	$ 863,099.94
7260	ANTICONVULSANTS - MISC.**	31,667	$ 2,447,446.65
4420	SYMPATHOMIMETICS**	28,338	$ 2,792,919.73
6510	OPIOID AGONISTS**	23,801	$ 1,016,722.41
6610	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*	23,636	$ 310,226.82
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**	21,287	$ 270,181.48
3940	HMG COA REDUCTASE INHIBITORS**	21,156	$ 395,673.72
5710	BENZODIAZEPINES**	17,507	$ 182,854.92
7510	CENTRAL MUSCLE RELAXANTS**	15,661	$ 287,458.13
3610	ACE INHIBITORS**	14,335	$ 140,103.07

Top 50 Drugs by Amount - Q2 2016

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
5925001500	ARIPIPRAZOLE	4417	$ 3,854,833.09	16	14
1235990240	LEDIPASVIR-SOFOSBUVIR	186	$ 3,404,424.58	12	12
8510002620	COAGULATION FACTOR VIIA (RECOMBINANT)	8	$ 3,360,081.36	84,000	12
8510001025	ANTIHEMOPHILIC FACTOR RAHF-PFM	19	$ 3,284,427.56	51,151	8
8510001020	ANTIHEMOPHILIC FACTOR (RECOMBINANT)	18	$ 1,456,732.86	26,116	11
5907005010	PALIPERIDONE PALMITATE	689	$ 1,236,613.21	1	23
5940002310	LURASIDONE HCL	1335	$ 1,208,399.22	17	15
2710400300	INSULIN GLARGINE	3645	$ 1,148,802.37	12	25
1235308000	SOFOSBUVIR	42	$ 1,065,448.17	16	16
4420101010	ALBUTEROL SULFATE	18843	$ 936,892.60	39	16
4420990270	FLUTICASONE-SALMETEROL	3231	$ 923,339.19	43	23
9410003000	GLUCOSE BLOOD	6801	$ 889,235.77	73	22
5915307010	QUETIAPINE FUMARATE	8077	$ 887,795.66	30	20
4927002510	ESOMEPRAZOLE MAGNESIUM	4106	$ 887,238.62	22	21
7260005700	PREGABALIN	2706	$ 821,939.73	50	21
6627001500	ADALIMUMAB	172	$ 687,474.44	1	11
3010002000	SOMATROPIN	199	$ 655,153.30	2	10
2710400500	INSULIN LISPRO (HUMAN)	1582	$ 608,629.11	12	21
4410008010	TIOTROPIUM BROMIDE MONOHYDRATE	2505	$ 582,110.41	22	24
1210990230	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	441	$ 562,451.65	19	19
1210990429	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE	237	$ 560,798.67	21	21
6135303010	GUANFACINE HCL (ADHD)	1795	$ 515,554.36	19	17
8240157000	PEGFILGRASTIM	107	$ 513,767.22	0	2
3030001000	CORTICOTROPIN	14	$ 510,652.38	2	4
2710400200	INSULIN ASPART	1425	$ 506,495.12	13	23
6599000220	OXYCODONE W/ ACETAMINOPHEN	10990	$ 505,528.33	57	15
6240552500	DIMETHYL FUMARATE	82	$ 504,215.94	18	9
4420990241	BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE	2621	$ 501,408.20	8	24
4530402000	DORNASE ALFA	151	$ 468,673.93	50	16
6510007510	OXYCODONE HCL	8937	$ 466,578.08	75	18
6629003000	ETANERCEPT	125	$ 435,921.20	2	14
6599170210	HYDROCODONE-ACETAMINOPHEN	22754	$ 431,734.80	61	15
9085006000	LIDOCAINE	1442	$ 431,439.52	52	15
6110002510	LISDEXAMFETAMINE DIMESYLATE	1764	$ 419,650.59	23	22
6140002010	METHYLPHENIDATE HCL	2432	$ 414,104.32	35	19
2710400600	INSULIN DETEMIR	1312	$ 402,484.48	12	23
7260003600	LACOSAMIDE	860	$ 401,287.06	55	15
1235302510	DACLATASVIR DIHYDROCHLORIDE	19	$ 399,193.23	21	21
8580005000	ECULIZUMAB	19	$ 381,738.00	96	1
6110990210	AMPHETAMINE-DEXTROAMPHETAMINE	2788	$ 370,641.92	28	19
3090685000	IDURSULFASE	19	$ 367,917.86	19	10
7210000700	CLOBAZAM	309	$ 349,134.39	57	13
6240306045	INTERFERON BETA-1A	69	$ 343,222.89	2	12
2153253000	EVEROLIMUS	24	$ 342,388.05	17	13
8510001510	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	31	$ 337,045.09	4,085	8
5907005000	PALIPERIDONE	401	$ 331,055.84	22	17
1910002010	IMMUNE GLOBULIN (HUMAN) IV	85	$ 330,297.64	426	2
9340002010	NALOXONE HCL	129	$ 313,349.90	1	6
9310002500	DEFERASIROX	57	$ 310,015.52	19	10
2755007010	SITAGLIPTIN PHOSPHATE	1288	$ 307,716.67	27	26

Top 50 Drugs by Amount - Q3 2016

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
5925001500	ARIPIPRAZOLE	4,240	$ 3,829,892.30	16	15
8510001025	ANTIHEMOPHILIC FACTOR RAHF-PFM	13	$ 3,138,689.01	137,656	20
1235990240	LEDIPASVIR-SOFOSBUVIR	158	$ 2,799,494.79	12	12
8510002620	COAGULATION FACTOR VIIA (RECOMBINANT)	6	$ 2,520,061.02	210,000	30
5907005010	PALIPERIDONE PALMITATE	665	$ 1,479,314.85	1	19
8510001020	ANTIHEMOPHILIC FACTOR (RECOMBINANT)	13	$ 1,446,033.00	75,789	25
5940002310	LURASIDONE HCL	1,296	$ 1,199,171.74	17	15
2710400300	INSULIN GLARGINE	3,451	$ 1,143,189.92	11	24
9410003000	GLUCOSE BLOOD	7,102	$ 939,242.88	73	22
1235308000	SOFOSBUVIR	39	$ 915,208.32	12	12
4420101010	ALBUTEROL SULFATE	17,945	$ 910,766.86	38	16
4420990270	FLUTICASONE-SALMETEROL	3,002	$ 879,853.11	42	22
5915307010	QUETIAPINE FUMARATE	8,153	$ 873,329.19	29	20
7260005700	PREGABALIN	2,789	$ 868,815.25	48	20
4927002510	ESOMEPRAZOLE MAGNESIUM	3,942	$ 861,984.55	21	21
3010002000	SOMATROPIN	217	$ 754,623.04	2	11
6627001500	ADALIMUMAB	160	$ 674,087.40	1	11
2710400500	INSULIN LISPRO	1,577	$ 664,388.76	11	20
1210990429	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE	253	$ 582,218.92	19	19
3030001000	CORTICOTROPIN	11	$ 544,655.87	3	5
6240552500	DIMETHYL FUMARATE	87	$ 540,600.22	15	7
4410008010	TIOTROPIUM BROMIDE MONOHYDRATE	2,181	$ 534,592.70	23	24
2710400200	INSULIN ASPART	1,321	$ 529,981.68	11	21
8240157000	PEGFILGRASTIM	105	$ 527,518.52	1	2
6629003000	ETANERCEPT	136	$ 515,580.21	2	13
4530402000	DORNASE ALFA	158	$ 510,810.10	53	18
1210990230	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	390	$ 503,832.40	20	20
6135303010	GUANFACINE HCL (ADHD)	1,796	$ 490,174.46	20	18
4420990241	BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE	2,424	$ 477,340.83	8	24
6599000220	OXYCODONE W/ ACETAMINOPHEN	10,855	$ 474,787.07	57	15
2153253000	EVEROLIMUS	26	$ 448,196.63	13	9
6510007510	OXYCODONE HCL	8,706	$ 443,106.22	75	18
7260003600	LACOSAMIDE	882	$ 428,883.48	52	14
6110002510	LISDEXAMFETAMINE DIMESYLATE	1,732	$ 409,027.49	23	22
6140002010	METHYLPHENIDATE HCL	2,345	$ 406,508.57	36	19
6599170210	HYDROCODONE-ACETAMINOPHEN	22,071	$ 404,677.94	59	15
7210000700	CLOBAZAM	336	$ 399,786.53	62	14
2710400600	INSULIN DETEMIR	1,297	$ 397,732.41	11	22
3890004000	EPINEPHRINE	636	$ 387,638.38	1	5
9085006000	LIDOCAINE	1,537	$ 387,257.59	59	16
9310002500	DEFERASIROX	70	$ 386,255.32	20	11
8510001510	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	29	$ 381,564.45	5,657	9
3090404500	NITISINONE	6	$ 375,016.98	77	13
700007000	TOBRAMYCIN	116	$ 364,743.49	107	11
6110990210	AMPHETAMINE-DEXTROAMPHETAMINE	2,801	$ 361,665.71	29	20
6240306045	INTERFERON BETA-1A	71	$ 356,733.76	1	10
1235302510	DACLATASVIR DIHYDROCHLORIDE	20	$ 320,151.51	12	12
1910002010	IMMUNE GLOBULIN (HUMAN) IV	88	$ 318,451.39	444	3
2135307000	TRASTUZUMAB	88	$ 303,659.65	1	2
2133502000	BEVACIZUMAB	302	$ 301,701.60	5	1

Top 50 Drugs by Amount - Q4 2016

Drug Code	Drug Name	Claim Count		Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
8510001025	ANTIHEMOPHILIC FACTOR RAHF-PFM	16.00	$	3,830,078.78	114,532	16
5925001500	ARIPIPRAZOLE	4,288.00	$	3,736,132.19	17	15
8510002620	COAGULATION FACTOR VIIA (RECOMBINANT)	6.00	$	2,520,061.02	210,000	30
1235990240	LEDIPASVIR-SOFOSBUVIR	143.00	$	2,330,403.27	12	12
8510001020	ANTIHEMOPHILIC FACTOR (RECOMBINANT)	15.00	$	1,646,384.77	56,593	20
5907005010	PALIPERIDONE PALMITATE	657.00	$	1,432,521.34	1	21
5940002310	LURASIDONE HCL	1,092.00	$	1,160,264.16	17	15
2710400300	INSULIN GLARGINE	3,240.00	$	1,105,835.88	12	25
1950206000	PALIVIZUMAB	409.00	$	1,086,912.38	1	20
9410003000	GLUCOSE BLOOD	7,091.00	$	950,744.77	73	22
4420101010	ALBUTEROL SULFATE	19,301.00	$	950,467.96	39	15
4420990270	FLUTICASONE-SALMETEROL	2,950.00	$	882,791.36	42	22
7260005700	PREGABALIN	2,594.00	$	833,824.70	48	20
4927002510	ESOMEPRAZOLE MAGNESIUM	3,734.00	$	829,043.22	21	20
3010002000	SOMATROPIN	219.00	$	813,914.39	2	10
5915307010	QUETIAPINE FUMARATE	7,895.00	$	747,871.32	28	19
6627001500	ADALIMUMAB	175.00	$	737,241.66	1	11
1235308000	SOFOSBUVIR	29.00	$	710,313.33	9	9
1235990265	SOFOSBUVIR-VELPATASVIR	46.00	$	691,074.97	10	10
2710400500	INSULIN LISPRO	1,450.00	$	632,595.93	10	20
1210990429	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE	256.00	$	593,770.89	20	20
4530402000	DORNASE ALFA	169.00	$	552,055.44	53	17
4410008010	TIOTROPIUM BROMIDE MONOHYDRATE	1,994.00	$	525,987.92	22	24
6629003000	ETANERCEPT	127.00	$	510,570.23	2	14
2710400200	INSULIN ASPART	1,200.00	$	505,962.40	11	20
2153253000	EVEROLIMUS	29.00	$	502,226.40	17	12
4420990241	BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE	2,358.00	$	494,814.93	8	24
6135303010	GUANFACINE HCL (ADHD)	1,796.00	$	486,986.45	19	18
6240552500	DIMETHYL FUMARATE	73.00	$	461,737.41	16	8
1210990230	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	347.00	$	458,269.72	20	20
1235302510	DACLATASVIR DIHYDROCHLORIDE	27.00	$	448,243.09	9	9
7210000700	CLOBAZAM	347.00	$	441,138.25	62	14
6599000220	OXYCODONE W/ ACETAMINOPHEN	9,986.00	$	438,852.33	58	15
6110002510	LISDEXAMFETAMINE DIMESYLATE	1,866.00	$	438,045.68	22	21
7260003600	LACOSAMIDE	800.00	$	430,259.25	61	15
6140002010	METHYLPHENIDATE HCL	2,347.00	$	405,406.70	35	19
8240157000	PEGFILGRASTIM	84.00	$	405,347.56	1	3
9310002500	DEFERASIROX	65.00	$	403,717.03	23	11
6510007510	OXYCODONE HCL	8,249.00	$	401,081.87	73	18
3090685000	IDURSULFASE	18.00	$	395,054.84	20	9
9340002010	NALOXONE HCL	169.00	$	379,844.11	0	7
7460003500	ETEPLIRSEN	4.00	$	377,640.68	14	3
0700007000	TOBRAMYCIN	118.00	$	377,466.68	111	11
2710400600	INSULIN DETEMIR	1,141.00	$	373,242.54	11	22
8580005000	ECULIZUMAB	18.00	$	372,012.00	97	1
6599170210	HYDROCODONE-ACETAMINOPHEN	20,021.00	$	367,433.47	61	16
9085006000	LIDOCAINE	1,582.00	$	353,261.05	53	13
8510001510	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	21.00	$	344,384.57	6,092	11
6110990210	AMPHETAMINE-DEXTROAMPHETAMINE	2,806.00	$	340,917.45	28	20
1910002010	IMMUNE GLOBULIN (HUMAN) IV	78.00	$	331,920.18	506	3

Top 50 Drugs by Claim Count - Q2 2016

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
6599170210	HYDROCODONE-ACETAMINOPHEN	22754	$ 431,734.80	61	15
4420101010	ALBUTEROL SULFATE	18843	$ 936,892.60	39	16
3610003000	LISINOPRIL	14561	$ 112,101.83	29	26
7260003000	GABAPENTIN	13819	$ 198,000.62	73	23
6610002000	IBUPROFEN	12078	$ 109,340.87	46	14
3400000310	AMLODIPINE BESYLATE	11096	$ 84,518.70	28	27
6599000220	OXYCODONE W/ ACETAMINOPHEN	10990	$ 505,528.33	57	15
3940001010	ATORVASTATIN CALCIUM	10885	$ 114,367.32	26	25
5710001000	ALPRAZOLAM	10873	$ 113,655.57	51	22
2725005000	METFORMIN HCL	10552	$ 154,378.99	52	25
2810001010	LEVOTHYROXINE SODIUM	10520	$ 151,985.98	29	29
6510007510	OXYCODONE HCL	8937	$ 466,578.08	75	18
5915307010	QUETIAPINE FUMARATE	8077	$ 887,795.66	30	20
5812008010	TRAZODONE HCL	8024	$ 81,416.15	29	21
4220003230	FLUTICASONE PROPIONATE (NASAL)	7427	$ 89,313.11	12	23
4450505010	MONTELUKAST SODIUM	7395	$ 129,844.81	23	22
5025006505	ONDANSETRON HCL	7143	$ 41,494.87	4	2
3320003010	METOPROLOL TARTRATE	7098	$ 51,804.42	43	23
6510005510	MORPHINE SULFATE	7034	$ 223,738.82	26	11
5816007010	SERTRALINE HCL	6896	$ 75,840.60	29	24
9410003000	GLUCOSE BLOOD	6801	$ 889,235.77	73	22
0120001010	AMOXICILLIN	6788	$ 69,996.82	55	6
3940007500	SIMVASTATIN	6556	$ 51,184.29	27	27
6410001000	ASPIRIN	6344	$ 34,488.04	23	22
5907007000	RISPERIDONE	6000	$ 96,284.57	35	21
6510009510	TRAMADOL HCL	5921	$ 57,772.67	56	16
3720003000	FUROSEMIDE	5803	$ 38,981.34	32	25
4920002010	RANITIDINE HCL	5752	$ 71,757.86	45	22
4155003000	LORATADINE	5652	$ 59,469.52	34	21
4927007010	PANTOPRAZOLE SODIUM	5625	$ 58,969.63	21	20
7720203200	CHOLECALCIFEROL	5440	$ 39,744.33	25	22
7210001000	CLONAZEPAM	5429	$ 55,461.22	45	22
5816004000	FLUOXETINE HCL	5382	$ 88,036.05	30	23
7510005010	CYCLOBENZAPRINE HCL	5372	$ 60,912.33	46	20
5816002010	CITALOPRAM HYDROBROMIDE	5088	$ 45,052.54	26	24
3615004020	LOSARTAN POTASSIUM	5034	$ 42,280.31	30	28
2210004500	PREDNISONE	5027	$ 45,841.60	18	9
3620101010	CLONIDINE HCL	4811	$ 62,298.47	38	22
7250001010	DIVALPROEX SODIUM	4746	$ 253,211.27	57	20
7720203000	ERGOCALCIFEROL	4503	$ 48,029.08	4	22
5710006000	LORAZEPAM	4501	$ 42,800.81	23	10
3330000700	CARVEDILOL	4477	$ 32,648.88	49	25
4155002010	CETIRIZINE HCL	4445	$ 46,247.02	43	20
0340001000	AZITHROMYCIN	4418	$ 60,953.03	7	4
5925001500	ARIPIPRAZOLE	4417	$ 3,854,833.09	16	14
3760004000	HYDROCHLOROTHIAZIDE	4335	$ 30,314.72	28	28
6020408010	ZOLPIDEM TARTRATE	4304	$ 41,894.72	23	23
7260004000	LAMOTRIGINE	4235	$ 237,991.43	44	21
7975001000	SODIUM CHLORIDE	4118	$ 11,397.59	445	1
6610005200	MELOXICAM	4106	$ 36,800.19	27	24

Top 50 Drugs by Claim Count - Q3 2016

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
6599170210	HYDROCODONE-ACETAMINOPHEN	22071	$ 404,677.94	59	15
4420101010	ALBUTEROL SULFATE	17945	$ 910,766.86	38	16
3610003000	LISINOPRIL	14035	$ 109,463.82	29	26
7260003000	GABAPENTIN	13628	$ 200,210.61	69	22
6610002000	IBUPROFEN	11458	$ 106,920.49	44	13
3940001010	ATORVASTATIN CALCIUM	11136	$ 116,059.67	25	25
3400000310	AMLODIPINE BESYLATE	10870	$ 83,105.53	27	26
6599000220	OXYCODONE W/ ACETAMINOPHEN	10855	$ 474,787.07	57	15
5710001000	ALPRAZOLAM	10812	$ 111,011.95	50	21
2725005000	METFORMIN HCL	10388	$ 167,045.72	55	27
2810001010	LEVOTHYROXINE SODIUM	10388	$ 155,233.35	28	28
6510007510	OXYCODONE HCL	8706	$ 443,106.22	75	18
5812008010	TRAZODONE HCL	8182	$ 85,754.47	28	21
5915307010	QUETIAPINE FUMARATE	8153	$ 873,329.19	29	20
6510005510	MORPHINE SULFATE	7214	$ 200,630.22	24	10
9410003000	GLUCOSE BLOOD	7102	$ 939,242.88	73	22
4450505010	MONTELUKAST SODIUM	7060	$ 118,862.53	21	21
5025006505	ONDANSETRON HCL	7049	$ 35,408.12	4	2
5816007010	SERTRALINE HCL	6972	$ 75,363.93	28	23
3320003010	METOPROLOL TARTRATE	6913	$ 51,970.35	43	23
4220003230	FLUTICASONE PROPIONATE (NASAL)	6673	$ 78,794.42	12	23
6410001000	ASPIRIN	6360	$ 33,676.08	23	22
3940007500	SIMVASTATIN	6143	$ 48,302.55	28	28
4927007010	PANTOPRAZOLE SODIUM	5979	$ 60,757.81	19	18
5907007000	RISPERIDONE	5962	$ 100,813.82	35	20
6510009510	TRAMADOL HCL	5814	$ 56,996.48	57	16
7720203200	CHOLECALCIFEROL	5801	$ 41,555.10	24	22
4920002010	RANITIDINE HCL	5700	$ 71,645.03	45	22
3720003000	FUROSEMIDE	5638	$ 38,320.15	29	23
120001010	AMOXICILLIN	5531	$ 57,202.63	52	6
5816004000	FLUOXETINE HCL	5419	$ 93,989.71	29	22
7510005010	CYCLOBENZAPRINE HCL	5357	$ 59,732.07	43	19
4155003000	LORATADINE	5275	$ 55,475.89	31	21
7210001000	CLONAZEPAM	5190	$ 55,058.03	44	21
7975001000	SODIUM CHLORIDE	5020	$ 13,745.22	460	1
3615004020	LOSARTAN POTASSIUM	4970	$ 41,428.88	25	23
3620101010	CLONIDINE HCL	4904	$ 64,594.37	37	21
5816002010	CITALOPRAM HYDROBROMIDE	4875	$ 43,344.16	24	23
2210004500	PREDNISONE	4609	$ 40,034.49	18	9
5025006500	ONDANSETRON	4606	$ 52,421.36	6	3
7250001010	DIVALPROEX SODIUM	4560	$ 232,343.82	55	19
5710006000	LORAZEPAM	4497	$ 43,287.66	22	10
7720203000	ERGOCALCIFEROL	4487	$ 47,766.96	4	22
3330000700	CARVEDILOL	4403	$ 33,303.87	47	24
5925001500	ARIPIPRAZOLE	4240	$ 3,829,892.30	16	15
7510009010	TIZANIDINE HCL	4231	$ 115,116.00	53	21
6610005200	MELOXICAM	4220	$ 36,965.32	27	24
7260004000	LAMOTRIGINE	4200	$ 247,172.82	43	21
3760004000	HYDROCHLOROTHIAZIDE	4181	$ 29,687.05	29	28
4155002010	CETIRIZINE HCL	4170	$ 45,142.77	40	20

Top 50 Drugs by Claim Count - Q4 2016

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
6599170210	HYDROCODONE-ACETAMINOPHEN	20021	$ 367,433.47	61	16
4420101010	ALBUTEROL SULFATE	19301	$ 950,467.96	39	15
3610003000	LISINOPRIL	12793	$ 102,955.51	32	29
7260003000	GABAPENTIN	12769	$ 186,635.62	70	22
6610002000	IBUPROFEN	11339	$ 107,259.48	47	13
3940001010	ATORVASTATIN CALCIUM	10703	$ 112,201.25	26	26
3400000310	AMLODIPINE BESYLATE	10082	$ 78,325.14	27	26
6599000220	OXYCODONE W/ ACETAMINOPHEN	9986	$ 438,852.33	58	15
5710001000	ALPRAZOLAM	9796	$ 105,865.78	50	22
2810001010	LEVOTHYROXINE SODIUM	9724	$ 148,347.60	30	29
2725005000	METFORMIN HCL	9702	$ 231,185.78	56	28
6510007510	OXYCODONE HCL	8249	$ 401,081.87	73	18
5812008010	TRAZODONE HCL	8101	$ 88,664.55	29	21
5915307010	QUETIAPINE FUMARATE	7895	$ 747,871.32	28	19
9410003000	GLUCOSE BLOOD	7091	$ 950,744.77	73	22
4450505010	MONTELUKAST SODIUM	6778	$ 113,460.24	21	21
5816007010	SERTRALINE HCL	6740	$ 73,828.41	27	22
0120001010	AMOXICILLIN	6670	$ 70,952.42	58	6
4220003230	FLUTICASONE PROPIONATE (NASAL)	6539	$ 78,146.84	13	24
3320003010	METOPROLOL TARTRATE	6424	$ 50,657.51	45	24
6410001000	ASPIRIN	6240	$ 34,429.09	24	23
6510005510	MORPHINE SULFATE	6184	$ 178,619.54	29	12
5025006505	ONDANSETRON HCL	6083	$ 35,887.99	5	2
7720203200	CHOLECALCIFEROL	5842	$ 43,455.74	24	22
5907007000	RISPERIDONE	5660	$ 91,465.09	35	20
3940007500	SIMVASTATIN	5575	$ 43,960.27	29	29
4927007010	PANTOPRAZOLE SODIUM	5573	$ 55,318.11	21	20
4920002010	RANITIDINE HCL	5479	$ 69,692.48	44	22
0340001000	AZITHROMYCIN	5450	$ 75,873.83	7	4
6510009510	TRAMADOL HCL	5227	$ 49,991.91	58	16
5816004000	FLUOXETINE HCL	5222	$ 94,505.77	26	20
2210004500	PREDNISONE	5099	$ 44,127.46	16	9
7510005010	CYCLOBENZAPRINE HCL	5058	$ 53,623.28	37	16
4155003000	LORATADINE	4965	$ 53,111.15	32	21
7210001000	CLONAZEPAM	4943	$ 52,514.14	45	22
3620101010	CLONIDINE HCL	4883	$ 68,442.96	38	22
3720003000	FUROSEMIDE	4873	$ 36,222.10	30	24
5025006500	ONDANSETRON	4844	$ 57,500.27	6	3
3615004020	LOSARTAN POTASSIUM	4631	$ 39,176.46	28	26
5816002010	CITALOPRAM HYDROBROMIDE	4431	$ 40,609.31	25	24
7250001010	DIVALPROEX SODIUM	4427	$ 217,346.48	58	20
7720203000	ERGOCALCIFEROL	4317	$ 46,102.27	4	23
5925001500	ARIPIPRAZOLE	4288	$ 3,736,132.19	17	15
6610005200	MELOXICAM	4252	$ 36,331.68	26	23
7975001000	SODIUM CHLORIDE	4211	$ 10,448.88	484	1
7510009010	TIZANIDINE HCL	4204	$ 109,194.06	51	21
4155002010	CETIRIZINE HCL	4127	$ 45,664.10	42	20
7260004000	LAMOTRIGINE	4120	$ 246,319.29	43	21
3330000700	CARVEDILOL	4103	$ 33,323.89	49	25
5710006000	LORAZEPAM	3962	$ 39,018.92	23	10

RXT6050D - Summarized DUR Activity Report

Between Apr 1, 2016 and Jun 30, 2016

Claims Summary:

RxCLAIM Status	Total Rxs	% of Total Rxs	Total Plan Paid	Total Member Paid
Paid	770,262	61.0%	$75,375,612.97	$0.00
Rejected	394,885	31.3%	$52,173,684.05	$0.00
Reversed	97,038	7.7%	-$18,841,737.47	$0.00
Totals	1,262,185	100%	$108,707,559.55	$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	64,269	23.2%	57,951	90.2%	0	0.0%	6,318	9.8%
TD - Therapeutic Duplication	0 - NS	60,772	22.0%	43,711	71.9%	8,259	13.6%	8,802	14.5%
ID - Ingredient Duplication	2 - Mod	49,689	18.0%	13,782	27.7%	32,115	64.6%	3,792	7.6%
DD - Drug-Drug Interaction	1 - Maj	39,572	14.3%	32,013	80.9%	3,864	9.8%	3,695	9.3%
LD - Low Dose Alert	0 - NS	28,464	10.3%	23,623	83.0%	0	0.0%	4,841	17.0%
HD - High Dose Alert	0 - NS	17,638	6.4%	15,482	87.8%	194	1.1%	1,962	11.1%
MN - Insufficnt Duration Alert	0 - NS	10,871	3.9%	7,876	72.4%	0	0.0%	2,995	27.6%
MX - Excessive Duration Alert	0 - NS	5,382	1.9%	4,978	92.5%	0	0.0%	404	7.5%
PA - Drug-Age Precaution	1 - Maj	26	0.0%	24	92.3%	0	0.0%	2	7.7%
Total All DURs		276,683	100.0%	199,440	72.1%	44,432	16.1%	32,811	11.9%

* 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	461	$5,103.26	$11.07	$0.00	28.6	80.7	57	31	$227.09
2	TRAZODONE HCL - QUETIAPINE	Message Only	442	$5,081.38	$11.50	$0.00	28.7	40.9	37	38	$579.19
3	SIMVASTATIN - FENOFIBRATE	Message Only	407	$6,202.83	$15.24	$0.00	32.9	33.1	56	31	$542.55
4	TRAZODONE HCL - CITALOPRAM	Message Only	404	$3,904.07	$9.66	$0.00	29.8	40.0	34	25	$238.02
5	TRAZODONE - QUETIAPINE FUMARATE	Message Only	377	$6,190.00	$16.42	$0.00	28.0	43.8	49	22	$290.24
6	SPIRONOLACT - LISINOPRIL	Message Only	360	$3,017.86	$8.38	$0.00	36.2	43.2	37	35	$222.29
7	SPIRONOLACTONE - LISINOPRIL	Message Only	364	$3,674.34	$10.09	$0.00	36.3	40.5	47	15	$125.62
8	TRAZODONE - CITALOPRAM HYDROBROMIDE	Message Only	354	$2,760.09	$7.80	$0.00	29.4	30.4	37	18	$90.96
9	DIVALPROEX - CLONAZEPAM	Message Only	364	$3,378.64	$9.28	$0.00	25.5	52.6	29	15	$122.93
10	FENOFIBRATE - ATORVASTATIN CALCIUM	Message Only	333	$3,795.01	$11.40	$0.00	32.1	32.1	49	15	$108.58
All Others			28,147	$2,943,661.42	$104.58	$0.00	25.2	49.2	3,432	3,450	$511,681.12
DD - Drug-Drug Interaction			32,013	$2,986,768.90	$93.30	$0.00	25.8	48.6	3,864	3,695	$514,228.59

* 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	473	$14,603.13	$30.87	$0.00	15.8	122.3	0	21	$511.14
2	KETOROLAC TROMETHAMINE	GERIATRIC MAX DLY = 2.00UN	Message Only	385	$3,037.50	$7.89	$0.00	1.0	5.2	0	28	$176.18
3	ZOLPIDEM TARTRATE	GERIATRIC MAX DLY = .50UN	Message Only	333	$1,625.92	$4.88	$0.00	29.6	29.6	0	18	$46.09
4	DEXAMETHASONE SODIUM PHOS	GERIATRIC MAX DLY = 2.60UN	Message Only	266	$4,467.86	$16.80	$0.00	1.0	12.8	0	18	$234.00
5	MIDAZOLAM HCL	GERIATRIC MAX DLY = 3.50UN	Message Only	199	$335.06	$1.68	$0.00	1.0	5.1	0	52	$92.27
6	GRANISETRON HCL	GERIATRIC MAX DLY = .85UN	Message Only	222	$5,858.81	$26.39	$0.00	1.0	1.8	0	9	$67.50
7	IBUPROFEN	ADULT MAX DLY = 4.00 UN	Message Only	202	$2,047.97	$10.14	$0.00	6.9	32.4	0	8	$94.60
8	KENALOG-40	GERIATRIC MAX DLY = 2.00UN	Message Only	200	$7,083.10	$35.42	$0.00	1.0	6.0	0	3	$127.18
9	INVEGA SUSTENNA	ADULT MAX DLY = .05 UN	Message Only	188	$344,373.93	$1,831.78	$0.00	26.0	1.5	0	6	$12,369.96
10	BETAMETHASONE SODIUM PHOS	GERIATRIC MAX DLY = 1.50UN	Message Only	183	$4,482.35	$24.49	$0.00	1.0	5.2	0	10	$236.49
All Others				12,831	$3,772,254.27	$294.00	$0.00	16.0	363.3	194	1,789	$695,810.92
HD - High Dose Alert				15,482	$4,160,169.90	$268.71	$0.00	14.9	306.5	194	1,962	$709,766.33

* 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	$32.03	$16.02	$0.00	9.0	30.0	734	0	$0.00
2	SODIUM CHLORIDE	SOD CHLORIDE INJ 0.9%	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	678	0	$0.00
3	OXYCODONE/ ACETAMINOPHEN	OXYCOD/APAP TAB 10-325MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	470	0	$0.00
4	PROAIR HFA	PROAIR HFA AER	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	392	0	$0.00
5	GABAPENTIN	GABAPENTIN CAP 300MG	Soft Reject	1	$10.46	$10.46	$0.00	7.0	7.0	385	0	$0.00
6	ALPRAZOLAM	ALPRAZOLAM TAB 2MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	367	0	$0.00
7	ALPRAZOLAM	ALPRAZOLAM TAB 1MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	363	0	$0.00
8	GABAPENTIN	GABAPENTIN CAP 300MG	Message Only	271	$3,495.96	$12.90	$0.00	30.6	98.7	0	43	$519.73
9	ZOLPIDEM TARTRATE	ZOLPIDEM TAB 10MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	272	0	$0.00
10	TRAMADOL HCL	TRAMADOL HCL TAB 50MG	Hard Reject	1	$12.72	$12.72	$0.00	30.0	120.0	268	0	$0.00
All Others				13,507	$1,909,203.87	$141.35	$0.00	27.4	90.7	28,186	3,749	$779,869.93
ID - Ingredient Duplication				13,782	$1,912,755.04	$138.79	$0.00	27.5	90.8	32,115	3,792	$780,389.66

* 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	1,339	$486.63	$0.36	$0.00	1.3	1.3	0	951	$223.87
2	ONDANSETRON ODT	GERIATRIC MIN DLY = 2.00UN	Message Only	680	$398.04	$0.59	$0.00	1.6	1.5	0	271	$133.88
3	IPRATROPIUM BROMIDE/ALBUT	GERIATRIC MIN DLY = 12.00UN	Message Only	468	$832.63	$1.78	$0.00	2.9	18.7	0	179	$161.49
4	METFORMIN HCL	ADULT MIN DLY = 1.70 UN	Message Only	498	$3,996.69	$8.03	$0.00	35.1	34.8	0	63	$577.16
5	VITAMIN D	ADULT MIN DLY = .14 UN	Message Only	510	$4,961.75	$9.73	$0.00	30.4	3.0	0	35	$357.37
6	HEPARIN SODIUM	GERIATRIC MIN DLY = 4.00UN	Message Only	332	$1,225.32	$3.69	$0.00	1.5	3.0	0	203	$480.93
7	GABAPENTIN	ADULT MIN DLY = 3.00 UN	Message Only	447	$4,672.94	$10.45	$0.00	32.8	53.7	0	30	$319.61
8	ALBUTEROL SULFATE	GERIATRIC MIN DLY = 9.00UN	Message Only	320	$516.23	$1.61	$0.00	3.7	19.0	0	84	$74.84
9	METFORMIN HCL	GERIATRIC MIN DLY = 1.70UN	Message Only	307	$1,065.72	$3.47	$0.00	36.9	36.4	0	42	$101.88
10	ONDANSETRON HCL	ADULT MIN DLY = 2.00 UN	Message Only	300	$3,366.38	$11.22	$0.00	18.6	11.5	0	34	$378.92
All Others				18,422	$1,614,904.12	$87.66	$0.00	24.5	54.3	0	2,949	$371,959.91
LD - Low Dose Alert				23,623	$1,636,426.45	$69.27	$0.00	22.1	45.6	0	4,841	$374,769.86

* 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	98	$756.93	$7.72	$0.00	30.0	34.3	0	6	$59.07
2	ATORVASTATIN CALCIUM	7 DAYS LATE REFILLING	Message Only	79	$868.13	$10.99	$0.00	29.4	29.6	0	2	$27.40
3	ATORVASTATIN CALCIUM	8 DAYS LATE REFILLING	Message Only	73	$797.42	$10.92	$0.00	29.7	29.7	0	1	$1.20
4	AMLODIPINE BESYLATE	7 DAYS LATE REFILLING	Message Only	66	$580.34	$8.79	$0.00	30.4	31.5	0	3	$22.78
4	GABAPENTIN	7 DAYS LATE REFILLING	Message Only	62	$856.27	$13.81	$0.00	29.6	92.7	0	7	$102.00
6	LISINOPRIL	8 DAYS LATE REFILLING	Message Only	63	$437.19	$6.94	$0.00	29.8	33.6	0	4	$14.53
7	MONTELUKAST SODIUM	7 DAYS LATE REFILLING	Message Only	56	$1,071.47	$19.13	$0.00	30.0	30.0	0	8	$111.05
7	METFORMIN HCL	8 DAYS LATE REFILLING	Message Only	54	$416.10	$7.71	$0.00	30.8	67.8	0	10	$86.63
9	LISINOPRIL	9 DAYS LATE REFILLING	Message Only	57	$435.19	$7.63	$0.00	30.0	32.6	0	6	$37.17
10	LEVOTHYROXINE SODIUM	8 DAYS LATE REFILLING	Message Only	55	$660.29	$12.01	$0.00	29.6	30.1	0	5	$70.58
All Others				57,288	$5,698,666.21	$99.47	$0.00	28.6	49.7	0	6,266	$982,731.40
LR - Underuse Precaution				57,951	$5,705,545.54	$98.45	$0.00	28.6	49.5	0	6,318	$983,263.81

* 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	343	$73.88	$0.22	$0.00	1.1	1.5	0	205	$28.22
2	IPRATROPIUM BROMIDE/ALBUT	MIN. DAYS THERAPY = 30	Message Only	475	$9,278.23	$19.53	$0.00	9.0	139.7	0	57	$821.12
3	METOPROLOL TARTRATE	MIN. DAYS THERAPY = 7	Message Only	305	$102.53	$0.34	$0.00	1.2	1.6	0	187	$6.33
4	CLONIDINE HCL	MIN. DAYS THERAPY = 7	Message Only	290	$644.47	$2.22	$0.00	1.6	3.7	0	111	$10.44
5	LEVETIRACETAM	MIN. DAYS THERAPY = 14	Message Only	289	$3,422.14	$11.84	$0.00	6.1	56.4	0	41	$268.00
6	ATORVASTATIN CALCIUM	MIN. DAYS THERAPY = 7	Message Only	202	$164.47	$0.81	$0.00	1.3	1.4	0	111	$38.48
7	AMLODIPINE BESYLATE	MIN. DAYS THERAPY = 7	Message Only	189	$72.30	$0.38	$0.00	1.2	1.3	0	100	$2.32
8	NICOTINE TRANSDERMAL SYST	MIN. DAYS THERAPY = 7	Message Only	135	$220.39	$1.63	$0.00	1.0	1.0	0	103	$231.48
9	FERROUS SULFATE	MIN. DAYS THERAPY = 30	Message Only	180	$953.98	$5.30	$0.00	13.0	26.2	0	56	$41.97
10	SULFAMETHOXAZOLE/ TRIMETHO	MIN. DAYS THERAPY = 5	Message Only	198	$1,008.81	$5.10	$0.00	2.2	6.4	0	33	$135.52
All Others				5,270	$288,879.37	$54.82	$0.00	2.4	19.5	0	1,991	$146,425.59
MN - Insufficnt Duration Alert				7,876	$304,820.57	$38.70	$0.00	2.9	24.6	0	2,995	$148,009.47

* 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	2,460	$25,841.79	$10.50	$0.00	30.2	65.3	0	112	$1,131.07
2	EPIPEN 2-PAK	MAX DAYS THERAPY = 1	Message Only	186	$103,507.30	$556.49	$0.00	2.3	2.3	0	33	$20,954.80
2	AZITHROMYCIN	MAX DAYS THERAPY = 5	Message Only	203	$4,575.14	$22.54	$0.00	12.6	21.3	0	16	$322.28
4	FLUCONAZOLE	MAX DAYS THERAPY = 1	Message Only	190	$2,699.96	$14.21	$0.00	3.4	3.5	0	13	$142.06
5	MAPAP	MAX DAYS THERAPY = 10	Message Only	174	$1,647.00	$9.47	$0.00	26.7	107.3	0	2	$15.72
6	DIPHENOXYLATE/ ATROPINE	MAX DAYS THERAPY = 14	Message Only	160	$5,103.63	$31.90	$0.00	26.8	108.2	0	9	$330.32
7	SENEXON-S	MAX DAYS THERAPY = 14	Message Only	122	$1,219.82	$10.00	$0.00	30.4	60.2	0	6	$46.35
8	POLYETHYLENE GLYCOL 3350	MAX DAYS THERAPY = 14	Message Only	93	$2,624.90	$28.22	$0.00	29.3	29.3	0	20	$672.85
9	LOPERAMIDE HCL	MAX DAYS THERAPY = 14	Message Only	87	$2,684.72	$30.86	$0.00	26.5	108.0	0	4	$108.37
10	TRAMADOL HYDROCHLORIDE/AC	MAX DAYS THERAPY = 5	Message Only	68	$896.71	$13.19	$0.00	22.3	74.7	0	10	$216.38
All Others				1,235	$238,312.71	$192.97	$0.00	25.5	65.9	0	179	$99,166.16
MX - Excessive Duration Alert				4,978	$389,113.68	$78.17	$0.00	25.8	61.9	0	404	$123,106.36

* 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 HCL	AGE LESS THAN 4	Message Only	9	$86.79	$9.64	$0.00	5.7	133.3	0	0	$0.00
2	PROMETHAZINE/ DEXTROMETHOR	AGE LESS THAN 4	Message Only	7	$70.07	$10.01	$0.00	9.1	75.0	0	0	$0.00
3	PROMETHAZINE-DM	AGE LESS THAN 4	Message Only	6	$42.49	$7.08	$0.00	12.5	93.3	0	0	$0.00
4	PROMETHAZINE HCL PLAIN	AGE LESS THAN 4	Message Only	0	$0.00	$0.00	$0.00	0.00	0.00	0	2	$9.63
4	PROMETHEGAN	AGE LESS THAN 4	Message Only	2	$194.10	$97.05	$0.00	3.5	11.0	0	0	$0.00
PA - Drug-Age Precaution				24	$393.45	$16.39	$0.00	8.2	96.1	0	2	$9.63

* 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	MORPHINE SULFATE	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,026	$6,077.85	$5.92	$0.00	4.4	15.4	0	710	$2,007.12
2	QUETIAPINE FUMARATE	ORAL ANTIPSYCHOTICS	Message Only	1,272	$19,598.69	$15.41	$0.00	27.0	39.4	0	120	$1,145.82
3	HYDROMORPHONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	911	$4,915.59	$5.40	$0.00	4.1	14.8	0	478	$1,319.01
4	HYDROCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,178	$18,196.97	$15.45	$0.00	15.1	58.5	0	176	$898.60
5	OXYCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,011	$29,309.53	$28.99	$0.00	13.1	51.9	0	210	$1,375.90
6	OXYCODONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	950	$27,394.33	$28.84	$0.00	21.8	96.6	0	82	$958.37
7	RISPERIDONE	ORAL ANTIPSYCHOTICS	Message Only	913	$10,765.56	$11.79	$0.00	26.6	43.5	0	67	$656.98
8	KETOROLAC TROMETHAMINE	NON-STEROIDAL ANTI-INFLAMMATOR	Message Only	705	$2,543.45	$3.61	$0.00	1.1	2.3	0	139	$356.45
9	LISINOPRIL	ANGIOTENSIN BLOCKERS	Message Only	671	$4,108.02	$6.12	$0.00	30.5	34.1	0	161	$475.54
10	LORAZEPAM	BENZODIAZEPINES	Message Only	559	$2,580.78	$4.62	$0.00	9.6	22.1	0	200	$237.88
All Others				34,515	$5,678,446.90	$164.52	$0.00	24.8	79.0	8,259	6,459	$1,308,356.81
TD - Therapeutic Duplication				43,711	$5,803,937.67	$132.78	$0.00	22.9	70.8	8,259	8,802	$1,317,788.48

* 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, 2016
Primary End Date:	Jun 30, 2016
Relative Date Description:	N/A
Select Report Group By:	Product
Top Values Displayed:	10
Display Report Description:	No

CONFIDENTIAL

RXT6050D - Summarized DUR Activity Report

Between Jul 1, 2016 and Sep 30, 2016

Oct 19, 2016
12:18:00 PM

Claims Summary:

RxCLAIM Status	Total Rxs	% of Total Rxs	Total Plan Paid	Total Member Paid
Paid	782,464	59.2%	$76,251,767.84	$0.00
Rejected	424,627	32.1%	$55,295,209.60	$0.00
Reversed	114,825	8.7%	-$17,767,834.21	$0.00
Totals	**1,321,916**	**100%**	**$113,779,143.23**	**$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	64,813	22.2%	58,229	89.8%	0	0.0%	6,584	10.2%
TD - Therapeutic Duplication	0 - NS	63,634	21.8%	44,262	69.6%	8,167	12.8%	11,205	17.6%
ID - Ingredient Duplication	2 - Mod	52,124	17.9%	14,018	26.9%	34,060	65.3%	4,046	7.8%
DD - Drug-Drug Interaction	1 - Maj	39,944	13.7%	31,181	78.1%	3,828	9.6%	4,935	12.4%
LD - Low Dose Alert	0 - NS	30,830	10.6%	24,807	80.5%	0	0.0%	6,023	19.5%
HD - High Dose Alert	0 - NS	18,048	6.2%	15,441	85.6%	158	0.9%	2,449	13.6%
MN - Insufficnt Duration Alert	0 - NS	16,287	5.6%	10,737	65.9%	0	0.0%	5,550	34.1%
MX - Excessive Duration Alert	0 - NS	5,664	1.9%	5,081	89.7%	0	0.0%	583	10.3%
PA - Drug-Age Precaution	1 - Maj	34	0.0%	31	91.2%	0	0.0%	3	8.8%
SX - Drug Gender Alert	1 - Maj	6	0.0%	6	100.0%	0	0.0%	0	0.0%
Total All DURs		**291,384**	**100.0%**	**203,793**	**69.9%**	**46,213**	**15.9%**	**41,378**	**14.2%**

* 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	TRAZODONE HCL - QUETIAPINE	Message Only	497	$5,512.52	$11.09	$0.00	27.8	38.5	56	51	$512.93
2	TRAZODONE - QUETIAPINE FUMARATE	Message Only	434	$6,889.56	$15.87	$0.00	27.7	44.0	51	42	$442.30
3	SIMVASTATIN - FENOFIBRATE	Message Only	415	$6,208.06	$14.96	$0.00	31.9	32.2	64	20	$272.46
4	CARISOPRODOL - ALPRAZOLAM	Message Only	385	$4,207.68	$10.93	$0.00	26.9	76.4	61	41	$272.84
5	SPIRONOLACT - LISINOPRIL	Message Only	362	$3,206.49	$8.86	$0.00	38.1	44.6	59	45	$265.92
6	SPIRONOLACTONE - LISINOPRIL	Message Only	353	$3,831.90	$10.86	$0.00	37.5	39.9	56	39	$341.74
7	TRAZODONE HCL - CITALOPRAM	Message Only	352	$3,251.03	$9.24	$0.00	28.7	36.7	38	51	$273.84
8	TRAZODONE - ONDANSETRON HCL	Message Only	234	$133.52	$0.57	$0.00	1.0	1.9	0	171	$83.91
9	FENOFIBRATE - ATORVASTATIN	Message Only	312	$8,893.78	$28.51	$0.00	29.1	29.1	41	37	$1,328.48
10	TRAZODONE - CITALOPRAM HYDROBROMIDE	Message Only	320	$2,324.22	$7.26	$0.00	28.2	29.1	27	37	$203.69
All Others			27,517	$2,610,257.86	$94.86	$0.00	24.3	45.8	3,375	4,401	$392,482.89
DD - Drug-Drug Interaction			**31,181**	**$2,654,716.62**	**$85.14**	**$0.00**	**24.8**	**45.0**	**3,828**	**4,935**	**$396,481.00**

* 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	KETOROLAC TROMETHAMINE	GERIATRIC MAX DLY = 2.00UN	Message Only	421	$4,673.68	$11.10	$0.00	1.0	5.9	0	36	$460.95
2	HYDROCODONE/ ACETAMINOPHEN	ADULT MAX DLY = 6.00 UN	Message Only	395	$11,792.93	$29.86	$0.00	14.9	115.4	0	15	$381.69
3	DEXAMETHASONE SODIUM PHOS	GERIATRIC MAX DLY = 2.60UN	Message Only	325	$4,941.96	$15.21	$0.00	1.0	16.1	0	14	$327.00
4	ZOLPIDEM TARTRATE	GERIATRIC MAX DLY = .50UN	Message Only	290	$964.72	$3.33	$0.00	29.7	29.7	0	20	$69.60
5	GRANISETRON HCL	GERIATRIC MAX DLY = .85UN	Message Only	240	$6,275.23	$26.15	$0.00	1.0	1.8	0	15	$118.75
6	CEFTRIAXONE SODIUM	GERIATRIC MAX DLY = 2.00UN	Message Only	241	$49,888.44	$207.01	$0.00	1.0	231.0	0	13	$387.20
7	KENALOG-40	GERIATRIC MAX DLY = 2.00UN	Message Only	239	$7,457.53	$31.20	$0.00	1.0	5.6	0	6	$291.27
8	MIDAZOLAM HCL	GERIATRIC MAX DLY = 3.50UN	Message Only	184	$437.96	$2.38	$0.00	1.0	6.7	0	55	$130.77
9	ENGERIX-B	GERIATRIC MAX DLY = 1.00UN	Message Only	163	$17,598.62	$107.97	$0.00	1.0	2.0	0	39	$4,201.06
10	VITAMIN D3	ADULT MAX DLY = 1.00 UN	Message Only	173	$1,454.05	$8.40	$0.00	29.2	62.7	0	27	$174.40
All Others				12,770	$4,340,180.96	$339.87	$0.00	15.3	124.1	158	2,209	$900,955.09
HD - High Dose Alert				**15,441**	**$4,445,666.08**	**$287.91**	**$0.00**	**14.0**	**111.2**	**158**	**2,449**	**$907,497.78**

* 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	SODIUM CHLORIDE	SOD CHLORIDE INJ 0.9%	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	1,133	0	$0.00
2	HYDROCODONE/ ACETAMINOPHEN	HYDROCO/APAP TAB 10-325MG	Hard Reject	3	$37.91	$12.64	$0.00	14.7	68.0	682	0	$0.00
3	OXYCODONE/ ACETAMINOPHEN	OXYCOD/APAP TAB 10-325MG	Hard Reject	1	$63.80	$63.80	$0.00	15.0	89.0	447	0	$0.00
4	GABAPENTIN	GABAPENTIN CAP 300MG	Soft Reject	1	$22.43	$22.43	$0.00	30.0	270.0	417	0	$0.00
5	ALPRAZOLAM	ALPRAZOLAM TAB 1MG	Hard Reject	1	$10.40	$10.40	$0.00	20.0	10.0	398	0	$0.00
6	PROAIR HFA	PROAIR HFA AER	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	396	0	$0.00
7	TRAMADOL HCL	TRAMADOL HCL TAB 50MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	329	0	$0.00
8	ALPRAZOLAM	ALPRAZOLAM TAB 2MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	321	0	$0.00
9	GABAPENTIN	GABAPENTIN CAP 300MG	Message Only	259	$3,284.30	$12.68	$0.00	31.8	93.6	0	58	$622.14
10	ZOLPIDEM TARTRATE	ZOLPIDEM TAB 10MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	305	0	$0.00
All Others				13,753	$1,999,313.34	$145.37	$0.00	27.1	90.8	29,632	3,988	$672,636.03
ID - Ingredient Duplication				**14,018**	**$2,002,732.18**	**$142.87**	**$0.00**	**27.1**	**90.9**	**34,060**	**4,046**	**$673,258.17**

* 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	1,469	$462.67	$0.31	$0.00	1.2	1.1	0	1,005	$243.22
2	ONDANSETRON ODT	GERIATRIC MIN DLY = 2.00UN	Message Only	789	$408.17	$0.52	$0.00	1.4	1.3	0	316	$149.38
3	HEPARIN SODIUM	GERIATRIC MIN DLY = 4.00UN	Message Only	421	$904.92	$2.15	$0.00	1.3	2.6	0	254	$663.43
4	METFORMIN HCL	ADULT MIN DLY = 1.70 UN	Message Only	502	$4,296.80	$8.56	$0.00	35.7	35.4	0	34	$305.87
5	IPRATROPIUM BROMIDE/ALBUT	GERIATRIC MIN DLY = 12.00UN	Message Only	239	$513.85	$2.15	$0.00	3.2	22.1	0	296	$250.33
6	VITAMIN D	ADULT MIN DLY = .14 UN	Message Only	494	$4,735.50	$9.59	$0.00	30.7	3.1	0	30	$302.88
7	ALBUTEROL SULFATE	GERIATRIC MIN DLY = 9.00UN	Message Only	363	$455.18	$1.25	$0.00	3.4	16.4	0	141	$48.32
8	GABAPENTIN	ADULT MIN DLY = 3.00 UN	Message Only	424	$4,426.46	$10.44	$0.00	31.5	52.5	0	35	$317.83
9	IPRATROPIUM BROMIDE/ALBUT	GERIATRIC MIN DLY = 9.00UN	Message Only	312	$210.54	$0.67	$0.00	1.9	9.0	0	141	$38.65
10	METFORMIN HCL	GERIATRIC MIN DLY = 1.70UN	Message Only	339	$999.45	$2.95	$0.00	35.1	35.0	0	77	$101.63
All Others				19,455	$1,781,116.47	$91.55	$0.00	23.1	51.3	0	3,694	$497,568.71
LD - Low Dose Alert				**24,807**	**$1,798,530.01**	**$72.50**	**$0.00**	**20.7**	**43.1**	**0**	**6,023**	**$499,990.25**

* 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	87	$654.24	$7.52	$0.00	29.2	31.3	0	7	$70.10
2	AMLODIPINE BESYLATE	7 DAYS LATE REFILLING	Message Only	74	$628.88	$8.50	$0.00	27.8	28.7	0	4	$33.87
2	LISINOPRIL	8 DAYS LATE REFILLING	Message Only	73	$628.72	$8.61	$0.00	29.6	32.6	0	5	$36.62
4	LEVOTHYROXINE SODIUM	7 DAYS LATE REFILLING	Message Only	69	$722.31	$10.47	$0.00	28.4	28.2	0	5	$52.76
5	ATORVASTATIN CALCIUM	8 DAYS LATE REFILLING	Message Only	66	$769.29	$11.66	$0.00	29.4	29.2	0	5	$30.73
6	ATORVASTATIN CALCIUM	7 DAYS LATE REFILLING	Message Only	65	$737.80	$11.35	$0.00	29.3	29.8	0	4	$44.87
6	AMLODIPINE BESYLATE	8 DAYS LATE REFILLING	Message Only	64	$570.49	$8.91	$0.00	29.1	29.1	0	5	$54.03
8	MONTELUKAST SODIUM	7 DAYS LATE REFILLING	Message Only	56	$1,077.84	$19.25	$0.00	29.6	29.6	0	9	$133.43
9	GABAPENTIN	7 DAYS LATE REFILLING	Message Only	56	$898.24	$16.04	$0.00	29.5	98.5	0	4	$62.52
9	ATORVASTATIN CALCIUM	9 DAYS LATE REFILLING	Message Only	54	$572.27	$10.60	$0.00	30.0	30.3	0	6	$58.57
All Others				57,565	$5,823,287.82	$101.16	$0.00	28.7	49.7	0	6,530	$920,116.92
LR - Underuse Precaution				**58,229**	**$5,830,547.90**	**$100.13**	**$0.00**	**28.7**	**49.6**	**0**	**6,584**	**$920,694.42**

* 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	597	$266.37	$0.45	$0.00	1.3	1.6	0	408	$75.20
2	PANTOPRAZOLE SODIUM	MIN. DAYS THERAPY = 7	Message Only	401	$94.00	$0.23	$0.00	1.1	1.1	0	350	$42.18
3	IPRATROPIUM BROMIDE/ALBUT	MIN. DAYS THERAPY = 30	Message Only	553	$7,979.66	$14.43	$0.00	8.5	120.4	0	127	$598.77
4	ATORVASTATIN CALCIUM	MIN. DAYS THERAPY = 7	Message Only	387	$351.02	$0.91	$0.00	1.3	1.5	0	288	$45.24
5	METOPROLOL TARTRATE	MIN. DAYS THERAPY = 7	Message Only	411	$199.27	$0.48	$0.00	1.2	1.8	0	256	$23.88
6	AMLODIPINE BESYLATE	MIN. DAYS THERAPY = 7	Message Only	318	$151.84	$0.48	$0.00	1.2	1.3	0	185	$26.03
7	CLONIDINE HCL	MIN. DAYS THERAPY = 7	Message Only	321	$542.33	$1.69	$0.00	1.4	4.3	0	159	$20.22
8	LIPITOR	MIN. DAYS THERAPY = 7	Message Only	218	$3,639.64	$16.70	$0.00	1.0	1.6	0	144	$2,236.51
9	LEVETIRACETAM	MIN. DAYS THERAPY = 14	Message Only	288	$3,335.63	$11.58	$0.00	5.4	61.3	0	61	$273.97
10	SERTRALINE HCL	MIN. DAYS THERAPY = 7	Message Only	178	$213.38	$1.20	$0.00	1.5	1.9	0	168	$14.71
All Others				7,065	$492,624.95	$69.73	$0.00	2.2	11.7	0	3,404	$244,873.61
MN - Insufficnt Duration Alert				**10,737**	**$509,398.09**	**$47.44**	**$0.00**	**2.4**	**16.0**	**0**	**5,550**	**$248,230.32**

* 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	2,428	$25,748.91	$10.60	$0.00	30.1	65.5	0	206	$2,240.48
2	EPIPEN 2-PAK	MAX DAYS THERAPY = 1	Message Only	228	$141,720.63	$621.58	$0.00	2.3	2.3	0	44	$29,857.56
3	FLUCONAZOLE	MAX DAYS THERAPY = 1	Message Only	236	$3,297.65	$13.97	$0.00	3.2	3.2	0	17	$279.52
4	MAPAP	MAX DAYS THERAPY = 10	Message Only	196	$1,859.70	$9.49	$0.00	26.7	119.8	0	10	$89.57
5	AZITHROMYCIN	MAX DAYS THERAPY = 5	Message Only	175	$3,461.06	$19.78	$0.00	12.9	17.5	0	14	$388.74
6	DIPHENOXYLATE/ ATROPINE	MAX DAYS THERAPY = 14	Message Only	130	$4,881.92	$37.55	$0.00	27.4	119.1	0	21	$974.85
7	SENEXON-S	MAX DAYS THERAPY = 14	Message Only	131	$1,220.11	$9.31	$0.00	30.6	58.2	0	6	$53.32
8	EPIPEN-JR 2-PAK	MAX DAYS THERAPY = 1	Message Only	95	$61,740.17	$649.90	$0.00	2.4	2.4	0	23	$16,172.60
9	POLYETHYLENE GLYCOL 3350	MAX DAYS THERAPY = 14	Message Only	101	$3,096.66	$30.66	$0.00	29.1	29.1	0	11	$290.94
10	LOPERAMIDE HCL	MAX DAYS THERAPY = 14	Message Only	75	$2,388.44	$31.85	$0.00	27.6	107.2	0	8	$283.29
All Others				1,286	$218,473.96	$169.89	$0.00	25.6	70.2	0	223	$112,444.71
MX - Excessive Duration Alert				**5,081**	**$467,889.21**	**$92.09**	**$0.00**	**25.1**	**61.3**	**0**	**583**	**$163,075.58**

* 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	9	$66.88	$7.43	$0.00	7.2	64.2	0	1	$4.00
1	PROMETHAZINE/ DEXTROMETHOR	AGE LESS THAN 4	Message Only	9	$88.27	$9.81	$0.00	6.2	59.3	0	1	$11.24
3	PROMETHAZINE HCL	AGE LESS THAN 4	Message Only	7	$52.63	$7.52	$0.00	6.7	137.1	0	0	$0.00
4	PROMETHEGAN	AGE LESS THAN 4	Message Only	3	$145.59	$48.53	$0.00	1.7	4.7	0	1	$26.90
5	PROMETHAZINE HCL PLAIN	AGE LESS THAN 4	Message Only	2	$25.01	$12.50	$0.00	5.0	150.0	0	0	$0.00
6	PROMETHAZINE/ PHENYLEPHRIN	AGE LESS THAN 4	Message Only	1	$33.33	$33.33	$0.00	34.0	85.0	0	0	$0.00
PA - Drug-Age Precaution				**31**	**$411.71**	**$13.28**	**$0.00**	**7.0**	**79.7**	**0**	**3**	**$42.14**

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

SX - Drug Gender 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	BICALUTAMIDE	GENERAL CONTRAINDICATION	Message Only	6	$72.54	$12.09	$0.00	7.0	7.0	0	0	$0.00
SX - Drug Gender Alert				**6**	**$72.54**	**$12.09**	**$0.00**	**7.0**	**7.0**	**0**	**0**	**$0.00**

* 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	MORPHINE SULFATE	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,194	$6,442.13	$5.40	$0.00	3.3	13.8	0	814	$2,368.70
2	HYDROMORPHONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	987	$6,452.91	$6.54	$0.00	3.4	12.2	0	592	$2,909.27
3	QUETIAPINE FUMARATE	ORAL ANTIPSYCHOTICS	Message Only	1,318	$19,877.08	$15.08	$0.00	26.6	39.2	0	119	$1,083.55
4	HYDROCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,218	$18,051.13	$14.82	$0.00	14.8	55.7	0	200	$886.01
5	OXYCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	1,014	$24,235.23	$23.90	$0.00	12.3	48.3	0	305	$1,399.16
6	OXYCODONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	943	$25,276.61	$26.80	$0.00	20.0	88.9	0	128	$1,171.71
7	RISPERIDONE	ORAL ANTIPSYCHOTICS	Message Only	885	$10,554.39	$11.93	$0.00	27.2	45.6	0	117	$1,052.33
8	KETOROLAC TROMETHAMINE	NON-STEROIDAL ANTI-INFLAMMATOR	Message Only	765	$3,345.95	$4.37	$0.00	1.1	2.4	0	131	$388.17
9	LISINOPRIL	ANGIOTENSIN BLOCKERS	Message Only	643	$3,981.69	$6.19	$0.00	31.1	34.3	0	233	$507.16
10	GABAPENTIN	GABAPENTIN AND RELATED	Message Only	708	$9,235.64	$13.04	$0.00	26.5	82.0	0	166	$718.08
All Others				34,587	$5,002,321.75	$144.63	$0.00	23.3	67.4	8,167	8,400	$813,767.00
TD - Therapeutic				**44,262**	**$5,129,774.51**	**$115.90**	**$0.00**	**21.7**	**61.8**	**8,167**	**11,205**	**$826,251.14**

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

RXT6050D - Summarized DUR Activity Report

Between Jul 1, 2016 and Sep 30, 2016

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
Duplication												

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

RXT6050D - Summarized DUR Activity Report

Between Jul 1, 2016 and Sep 30, 2016

Selected Filters

Client(s): Nevada Medicaid - HPES

Carrier(s): ALL

Account(s): ALL

Group(s): ALL

Date Type:	Date Submitted
Primary Start Date:	Jul 1, 2016
Primary End Date:	Sep 30, 2016
Relative Date Description:	N/A
Select Report Group By:	Product
Top Values Displayed:	10
Display Report Description:	No

RXT6050D - Summarized DUR Activity Report

Between Oct 1, 2016 and Dec 31, 2016

Claims Summary:

RxCLAIM Status	Total Rxs	% of Total Rxs	Total Plan Paid	Total Member Paid
Paid	722,785	60.6%	$74,474,102.14	$0.00
Rejected	382,038	32.0%	$52,470,458.77	$0.00
Reversed	87,877	7.4%	-$18,664,333.27	$0.00
Totals	1,192,700	100%	$108,280,227.64	$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	61,413	24.1%	55,080	89.7%	0	0.0%	6,333	10.3%
TD - Therapeutic Duplication	0 - NS	53,574	21.0%	38,838	72.5%	7,632	14.2%	7,104	13.3%
ID - Ingredient Duplication	2 - Mod	50,015	19.6%	13,415	26.8%	32,849	65.7%	3,751	7.5%
DD - Drug-Drug Interaction	1 - Maj	34,223	13.4%	27,827	81.3%	3,374	9.9%	3,022	8.8%
LD - Low Dose Alert	0 - NS	25,992	10.2%	21,960	84.5%	0	0.0%	4,032	15.5%
HD - High Dose Alert	0 - NS	14,695	5.8%	12,924	87.9%	136	0.9%	1,635	11.1%
MN - Insufficnt Duration Alert	0 - NS	9,927	3.9%	7,304	73.6%	0	0.0%	2,623	26.4%
MX - Excessive Duration Alert	0 - NS	5,187	2.0%	4,672	90.1%	0	0.0%	515	9.9%
PA - Drug-Age Precaution	1 - Maj	48	0.0%	43	89.6%	0	0.0%	5	10.4%
SX - Drug Gender Alert	1 - Maj	8	0.0%	8	100.0%	0	0.0%	0	0.0%
Total All DURs		255,082	100.0%	182,071	71.4%	43,991	17.2%	29,020	11.4%

* 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	TRAZODONE HCL - QUETIAPINE	Message Only	480	$5,470.02	$11.40	$0.00	28.3	38.7	45	37	$518.06
2	TRAZODONE - QUETIAPINE FUMARATE	Message Only	365	$5,575.98	$15.28	$0.00	28.2	42.3	46	30	$395.56
3	SIMVASTATIN - FENOFIBRATE	Message Only	314	$4,915.29	$15.65	$0.00	33.2	33.1	56	16	$169.61
4	SPIRONOLACTONE - LISINOPRIL	Message Only	307	$3,527.50	$11.49	$0.00	38.7	43.2	48	29	$272.56
5	CARISOPRODOL - ALPRAZOLAM	Message Only	330	$3,512.24	$10.64	$0.00	28.2	81.1	36	15	$133.42
6	SPIRONOLACT - LISINOPRIL	Message Only	317	$2,762.14	$8.71	$0.00	36.4	40.9	34	22	$154.88
7	TRAZODONE HCL - CITALOPRAM	Message Only	305	$3,176.14	$10.41	$0.00	29.9	38.3	32	28	$252.76
8	FENOFIBRATE - ATORVASTATIN CALCIUM	Message Only	304	$3,503.85	$11.53	$0.00	32.6	32.9	34	14	$137.34
9	DIVALPROEX - CLONAZEPAM	Message Only	293	$2,902.47	$9.91	$0.00	27.5	56.7	38	12	$135.12
10	FENOFIBRATE - ATORVASTATIN	Message Only	282	$7,249.23	$25.71	$0.00	30.8	30.8	42	14	$489.71
All Others			24,530	$2,581,920.15	$105.26	$0.00	25.2	45.7	2,963	2,805	$311,214.28
DD - Drug-Drug Interaction			27,827	$2,624,515.01	$94.32	$0.00	25.9	45.5	3,374	3,022	$313,873.30

* 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	397	$11,163.75	$28.12	$0.00	14.4	110.6	0	13	$313.07
2	KETOROLAC TROMETHAMINE	GERIATRIC MAX DLY = 2.00UN	Message Only	328	$4,968.26	$15.15	$0.00	1.0	6.1	0	25	$451.12
3	ZOLPIDEM TARTRATE	GERIATRIC MAX DLY = .50UN	Message Only	263	$822.83	$3.13	$0.00	30.5	30.6	0	13	$34.03
4	GRANISETRON HCL	GERIATRIC MAX DLY = .85UN	Message Only	233	$2,994.24	$12.85	$0.00	1.0	1.0	0	23	$165.75
5	MIDAZOLAM HCL	GERIATRIC MAX DLY = 3.50UN	Message Only	147	$421.21	$2.87	$0.00	1.0	8.4	0	46	$147.69
6	INVEGA SUSTENNA	ADULT MAX DLY = .05 UN	Message Only	176	$362,318.39	$2,058.63	$0.00	26.7	1.5	0	12	$17,147.76
7	IBUPROFEN	ADULT MAX DLY = 4.00 UN	Message Only	168	$1,800.68	$10.72	$0.00	7.7	36.5	0	10	$116.60
8	MIDAZOLAM HCL	GERIATRIC MAX DLY = .70UN	Message Only	168	$186.79	$1.11	$0.00	1.0	1.3	0	3	$11.46
9	BETAMETHASONE SODIUM PHOS	GERIATRIC MAX DLY = 1.50UN	Message Only	151	$4,027.75	$26.67	$0.00	1.0	5.4	0	12	$260.45
10	DEXAMETHASONE SODIUM PHOS	GERIATRIC MAX DLY = 2.60UN	Message Only	139	$1,999.18	$14.38	$0.00	1.0	19.0	0	7	$216.00
All Others				10,754	$3,866,985.58	$359.59	$0.00	14.8	131.2	136	1,471	$939,136.64
HD - High Dose Alert				12,924	$4,257,688.66	$329.44	$0.00	14.0	114.2	136	1,635	$958,000.57

* 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	SODIUM CHLORIDE	SOD CHLORIDE INJ 0.9%	Soft Reject	1	$11.51	$11.51	$0.00	1.0	500.0	779	0	$0.00
2	HYDROCODONE/ ACETAMINOPHEN	HYDROCO/APAP TAB 10-325MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	743	0	$0.00
3	OXYCODONE/ ACETAMINOPHEN	OXYCOD/APAP TAB 10-325MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	443	0	$0.00
4	PROAIR HFA	PROAIR HFA AER	Soft Reject	1	$61.40	$61.40	$0.00	16.0	8.5	408	0	$0.00
5	GABAPENTIN	GABAPENTIN CAP 300MG	Soft Reject	0	$0.00	$0.00	$0.00	0.00	0.00	358	0	$0.00
6	ALPRAZOLAM	ALPRAZOLAM TAB 1MG	Hard Reject	1	$10.86	$10.86	$0.00	10.0	30.0	337	0	$0.00
7	ALPRAZOLAM	ALPRAZOLAM TAB 2MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	337	0	$0.00
8	TRAMADOL HCL	TRAMADOL HCL TAB 50MG	Hard Reject	1	$10.69	$10.69	$0.00	4.0	24.0	286	0	$0.00
9	GABAPENTIN	GABAPENTIN CAP 300MG	Message Only	208	$2,520.06	$12.12	$0.00	31.0	88.8	0	57	$617.50
10	ZOLPIDEM TARTRATE	ZOLPIDEM TAB 10MG	Hard Reject	0	$0.00	$0.00	$0.00	0.00	0.00	264	0	$0.00
All Others				13,203	$1,994,796.59	$151.09	$0.00	27.4	102.9	28,894	3,694	$619,322.16
ID - Ingredient Duplication				13,415	$1,997,411.11	$148.89	$0.00	27.4	102.7	32,849	3,751	$619,939.66

* 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	1,049	$264.65	$0.25	$0.00	1.2	1.2	0	653	$132.10
2	ONDANSETRON ODT	GERIATRIC MIN DLY = 2.00UN	Message Only	702	$355.35	$0.51	$0.00	1.4	1.2	0	208	$82.74
3	IPRATROPIUM BROMIDE/ALBUT	GERIATRIC MIN DLY = 9.00UN	Message Only	457	$284.36	$0.62	$0.00	1.8	7.4	0	198	$112.24
4	VITAMIN D	ADULT MIN DLY = .14 UN	Message Only	479	$4,625.27	$9.66	$0.00	30.8	3.2	0	39	$365.14
5	METFORMIN HCL	ADULT MIN DLY = 1.70 UN	Message Only	429	$3,797.61	$8.85	$0.00	35.0	34.4	0	33	$267.47
6	GABAPENTIN	ADULT MIN DLY = 3.00 UN	Message Only	394	$4,164.19	$10.57	$0.00	32.3	52.2	0	27	$239.43
7	ALBUTEROL SULFATE	GERIATRIC MIN DLY = 9.00UN	Message Only	360	$625.17	$1.74	$0.00	4.0	21.4	0	58	$40.22
8	PROPRANOLOL HCL	ADULT MIN DLY = 3.00 UN	Message Only	315	$5,246.83	$16.66	$0.00	29.7	52.9	0	29	$440.43
9	CITALOPRAM HYDROBROMIDE	ADULT MIN DLY = 2.00 UN	Message Only	286	$3,018.06	$10.55	$0.00	29.8	29.8	0	28	$311.50
10	METFORMIN HCL	GERIATRIC MIN DLY = 1.70UN	Message Only	266	$729.97	$2.74	$0.00	35.4	35.1	0	35	$34.92
All Others				17,223	$2,351,066.48	$136.51	$0.00	24.6	48.3	0	2,724	$657,450.37
LD - Low Dose Alert				21,960	$2,374,177.94	$108.11	$0.00	22.7	41.7	0	4,032	$659,476.56

* 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	$698.63	$8.52	$0.00	29.5	32.7	0	5	$49.99
2	ATORVASTATIN CALCIUM	7 DAYS LATE REFILLING	Message Only	77	$867.72	$11.27	$0.00	30.0	30.0	0	6	$82.07
3	METFORMIN HCL	7 DAYS LATE REFILLING	Message Only	74	$606.10	$8.19	$0.00	30.8	63.4	0	2	$20.72
4	LISINOPRIL	8 DAYS LATE REFILLING	Message Only	71	$580.63	$8.18	$0.00	29.6	31.5	0	2	$11.93
5	GABAPENTIN	7 DAYS LATE REFILLING	Message Only	63	$1,046.32	$16.61	$0.00	29.5	100.7	0	7	$142.00
6	ATORVASTATIN CALCIUM	8 DAYS LATE REFILLING	Message Only	64	$745.38	$11.65	$0.00	29.7	29.4	0	3	$15.34
7	LEVOTHYROXINE SODIUM	8 DAYS LATE REFILLING	Message Only	62	$771.44	$12.44	$0.00	29.7	29.3	0	3	$30.68
8	LISINOPRIL	9 DAYS LATE REFILLING	Message Only	58	$461.35	$7.95	$0.00	30.0	31.1	0	5	$34.75
9	AMLODIPINE BESYLATE	7 DAYS LATE REFILLING	Message Only	57	$472.96	$8.30	$0.00	31.1	31.6	0	5	$54.18
10	PROAIR HFA	10 DAYS LATE REFILLING	Message Only	57	$3,581.65	$62.84	$0.00	21.4	9.5	0	4	$296.83
All Others				54,415	$5,759,480.70	$105.84	$0.00	28.8	49.9	0	6,291	$896,634.02
LR - Underuse Precaution				55,080	$5,769,312.88	$104.74	$0.00	28.8	49.8	0	6,333	$897,372.51

* 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	577	$9,423.95	$16.33	$0.00	10.3	141.9	0	100	$887.85
2	PANTOPRAZOLE SODIUM	MIN. DAYS THERAPY = 7	Message Only	290	$76.27	$0.26	$0.00	1.1	1.1	0	178	$35.38
3	LISINOPRIL	MIN. DAYS THERAPY = 7	Message Only	240	$75.04	$0.31	$0.00	1.1	1.4	0	115	$38.56
4	AMLODIPINE BESYLATE	MIN. DAYS THERAPY = 7	Message Only	207	$78.04	$0.38	$0.00	1.1	1.2	0	108	$2.41
5	CLONIDINE HCL	MIN. DAYS THERAPY = 7	Message Only	222	$476.55	$2.15	$0.00	1.6	5.0	0	62	$24.57
6	METOPROLOL TARTRATE	MIN. DAYS THERAPY = 7	Message Only	177	$85.84	$0.48	$0.00	1.2	1.7	0	92	$12.96
7	ATORVASTATIN CALCIUM	MIN. DAYS THERAPY = 7	Message Only	160	$180.49	$1.13	$0.00	1.3	1.5	0	88	$10.79
8	FERROUS SULFATE	MIN. DAYS THERAPY = 30	Message Only	177	$725.06	$4.10	$0.00	11.0	20.5	0	67	$34.05
9	SULFAMETHOXAZOLE/ TRIMETHO	MIN. DAYS THERAPY = 5	Message Only	170	$1,085.70	$6.39	$0.00	2.2	9.5	0	20	$96.60
10	LIPITOR	MIN. DAYS THERAPY = 7	Message Only	123	$1,981.39	$16.11	$0.00	1.0	1.5	0	66	$1,204.98
All Others				4,961	$370,655.05	$74.71	$0.00	2.6	26.0	0	1,727	$92,631.15
MN - Insufficnt Duration Alert				7,304	$384,843.38	$52.69	$0.00	3.1	29.9	0	2,623	$94,979.30

* 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	2,200	$23,053.50	$10.48	$0.00	30.2	65.3	0	191	$1,842.37
2	AZITHROMYCIN	MAX DAYS THERAPY = 5	Message Only	212	$4,480.74	$21.14	$0.00	10.2	18.9	0	15	$311.11
2	MAPAP	MAX DAYS THERAPY = 10	Message Only	211	$1,959.98	$9.29	$0.00	25.4	123.0	0	16	$147.40
4	FLUCONAZOLE	MAX DAYS THERAPY = 1	Message Only	195	$2,532.53	$12.99	$0.00	3.0	3.2	0	21	$485.65
5	SENEXON-S	MAX DAYS THERAPY = 14	Message Only	167	$1,582.81	$9.48	$0.00	31.4	59.4	0	0	$0.00
6	EPIPEN 2-PAK	MAX DAYS THERAPY = 1	Message Only	120	$73,684.90	$614.04	$0.00	2.2	2.2	0	25	$19,090.79
7	DIPHENOXYLATE/ ATROPINE	MAX DAYS THERAPY = 14	Message Only	103	$3,743.93	$36.35	$0.00	27.6	107.0	0	16	$467.26
8	POLYETHYLENE GLYCOL 3350	MAX DAYS THERAPY = 14	Message Only	102	$3,141.33	$30.80	$0.00	29.5	29.5	0	9	$232.89
9	TRAMADOL HYDROCHLORIDE/ AC	MAX DAYS THERAPY = 5	Message Only	74	$1,005.57	$13.59	$0.00	17.7	61.8	0	5	$64.89
10	DOCUSATE SODIUM & SENNA S	MAX DAYS THERAPY = 14	Message Only	70	$684.11	$9.77	$0.00	30.4	63.1	0	5	$23.92
All Others				1,218	$260,292.76	$213.71	$0.00	23.8	73.7	0	212	$150,930.79
MX - Excessive Duration Alert				4,672	$376,162.16	$80.51	$0.00	25.4	63.6	0	515	$173,597.07

* 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	15	$96.06	$6.40	$0.00	9.1	81.9	0	0	$0.00
2	PROMETHAZINE HCL	AGE LESS THAN 4	Message Only	9	$174.99	$19.44	$0.00	9.4	88.7	0	1	$11.75
3	NITROFURANTOIN	AGE LESS THAN 4	Message Only	7	$1,691.76	$241.68	$0.00	16.3	157.1	0	1	$407.43
3	PROMETHAZINE/ DEXTROMETHOR	AGE LESS THAN 4	Message Only	5	$53.79	$10.76	$0.00	11.4	83.2	0	3	$34.86
5	NITROFURANTOIN MACROCRYST	AGE LESS THAN 4	Message Only	2	$39.08	$19.54	$0.00	30.0	15.0	0	0	$0.00
5	PROMETHAZINE HCL PLAIN	AGE LESS THAN 4	Message Only	2	$11.98	$5.99	$0.00	3.5	50.0	0	0	$0.00
5	PROMETHAZINE/CODEINE	AGE LESS THAN 4	Message Only	2	$20.80	$10.40	$0.00	9.5	180.0	0	0	$0.00
8	NITROFURANTOIN MONOHYDRAT	AGE LESS THAN 4	Message Only	1	$20.56	$20.56	$0.00	5.0	10.0	0	0	$0.00
PA - Drug-Age Precaution				43	$2,109.02	$49.05	$0.00	11.2	94.0	0	5	$454.04

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

SX - Drug Gender 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	BICALUTAMIDE	GENERAL CONTRAINDICATION	Message Only	8	$102.45	$12.81	$0.00	9.6	9.6	0	0	$0.00
SX - Drug Gender Alert				8	$102.45	$12.81	$0.00	9.6	9.6	0	0	$0.00

* 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	MORPHINE SULFATE	SHORT ACTING NARCOTIC ANALGESI	Message Only	858	$5,687.99	$6.63	$0.00	3.8	14.9	0	495	$1,786.48
2	QUETIAPINE FUMARATE	ORAL ANTIPSYCHOTICS	Message Only	1,233	$20,168.67	$16.36	$0.00	27.5	39.9	0	118	$2,240.65
3	HYDROCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	989	$14,987.11	$15.15	$0.00	15.4	61.2	0	135	$535.95
4	HYDROMORPHONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	749	$5,281.49	$7.05	$0.00	4.5	17.7	0	297	$1,515.53
5	OXYCODONE/ ACETAMINOPHEN	SHORT ACTING NARCOTIC ANALGESI	Message Only	812	$21,652.66	$26.67	$0.00	13.8	53.5	0	186	$1,634.04
6	OXYCODONE HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	808	$22,152.39	$27.42	$0.00	22.5	96.1	0	106	$1,258.36
7	RISPERIDONE	ORAL ANTIPSYCHOTICS	Message Only	804	$9,615.10	$11.96	$0.00	27.6	46.0	0	83	$901.38
8	GABAPENTIN	GABAPENTIN AND RELATED	Message Only	598	$8,861.82	$14.82	$0.00	29.0	92.6	0	92	$736.19
9	KETOROLAC TROMETHAMINE	NON-STEROIDAL ANTI-INFLAMMATOR	Message Only	578	$2,820.65	$4.88	$0.00	1.1	2.2	0	98	$442.55
10	TRAMADOL HCL	SHORT ACTING NARCOTIC ANALGESI	Message Only	617	$6,075.79	$9.85	$0.00	21.4	84.9	0	43	$176.87
All Others				30,792	$5,222,582.94	$169.61	$0.00	25.3	70.2	7,632	5,451	$871,334.76

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

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
TD - Therapeutic Duplication				38,838	$5,339,886.61	$137.49	$0.00	23.6	66.0	7,632	7,104	$882,562.76

* 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, 2016
Primary End Date:	Dec 31, 2016
Relative Date Description:	N/A
Select Report Group By:	Product
Top Values Displayed:	10
Display Report Description:	No