ABOUT THE SURVEY

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

This report covers the period October 1, 2018 to September 30, 2019 and is **due for submission to CMS Central Office by no later than September 30, 2020. Answering the attached questions and returning the requested materials as attachments to the report will constitute compliance with the above-mentioned statutory requirement.**

☒ I have read the information about this survey.

I. DEMOGRAPHIC INFORMATION

Medicaid Agency Information

Identify state person responsible for DUR Annual Report Preparation.

First Name: Holly

Last Name: Long

Email Address: hlong@dhcfp.nv.gov

Area Code/Phone Number: 775-684-3150

1. On average, how many of your state's Medicaid beneficiaries are enrolled in your state's Medicaid Fee-For-Service (FFS) program that have a pharmacy benefit?

   185,958 beneficiaries

2. On average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)?

   481,090 beneficiaries

II. PROSPECTIVE DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) vendor.

   - ○ State-Operated
   - ◉ Contractor
   - ○ Other

   a. Vendor Name

   OptumRx

b. If not state-operated, is the POS vendor also the MMIS fiscal agent or a separate PBM?

- ○ POS vendor is the fiscal agent
- ◉ POS vendor is a separate PBM
- ○ No

2. Identify ProDUR criteria source.

- ☐ First Databank
- ☒ Medi-Span
- ☐ MICROMEDEX
- ☐ Other

Please specify.

3. Are new ProDUR criteria approved by the DUR Board?

- ○ Yes
- ◉ No

If "No," please explain.

Medi-Span provides the ProDUR criteria for the State of Nevada. The DUR Board does not review or approve the ProDUR criteria.

4. When the pharmacist receives a level-one ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?

   - (●) Yes
   - ( ) No
   - ( ) Varies by alert type

   If "varies", please explain.

5. Do you receive and review follow-up reports providing individual pharmacy provider DUR alert override activity in summary and/or in detail?

   - ( ) Yes

   a. How often do you receive reports?

      - ☐ Monthly
      - ☐ Quarterly
      - ☐ Annually
      - ☐ Ad hoc (on request)
      - ☐ Other

      Please explain.

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

○ Yes

By what method do you follow up?

☐ Contact Pharmacy

☐ Refer to Program Integrity for Review

☐ Other

Please explain.

○ No

Please explain.

◉ No

Please explain.

A process to identify individual pharmacy provider DUR alert override activity in summary and/or in detail has not yet been implemented.

6. **Early Refill**

b. At what percent threshold do you set your system to edit?

i. Non-controlled drugs:

80 %

ii. Schedule II controlled drugs:

90 %

iii. Schedule III through V controlled drugs:

90 %

b. **For non-controlled drugs:**

When an early refill message occurs, does the state require prior authorization?

- (●) Yes
- ( ) No
- ( ) Dependent on medication or situation

If "Yes" or "Dependent on medication or situation," who obtains authorization?

- ( ) Pharmacist
- ( ) Prescriber
- (●) Pharmacist or Prescriber

If "No," can the pharmacist override at the point of service?

- ( ) Yes
- ( ) No

c. **For controlled drugs:**

When an early refill message occurs, does the state require prior authorization?

- (●) Yes
- ( ) No

If "Yes," who obtains authorization?

- ( ) Pharmacist
- ( ) Prescriber
- (●) Pharmacist or Prescriber

If "No," can the pharmacist override at the point of service?

- ( ) Yes
- ( ) No

7. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your state's policy allow the pharmacist to override for situations such as:

   a. Lost/stolen Rx

   - ○ Yes
   - ◉ No
   - ○ Overrides are only allowed by a pharmacist through a prior authorization

   b. Vacation

   - ○ Yes
   - ◉ No
   - ○ Overrides are only allowed by a pharmacist through a prior authorization

   c. Other, please explain

8. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?

   - ○ Yes
   - ◉ No

   If "Yes," please explain your edit.

If "No," do you plan to implement this edit?

- ○ Yes
- ◉ No

9. Does the state Medicaid agency or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?

   - ○ Yes
   - ◉ No

10. Does the state Medicaid agency have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled, chronic medication refills at the same time, the state would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?

    - ◉ Yes
    - ○ No

11. For drugs not on your formulary, does your agency have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?

◉ Yes

What is the preauthorization process?

The prescribing provider may fax or call the OptumRx Prior Authorization Call Center to request authorization. Medicaid Services Manual (MSM) Chapter 1200 - Prescribed Drugs includes criteria which states that drugs not on the PDL, but within drug classes reviewed by the Silver State Scripts Board (formerly known as the P&T Committee), require prior authorization, unless exempt under NRS or

○ No

Please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.

a. Does your program provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation?

◉ Yes

What is the process?

The pharmacy may call the OptumRx Call Center to request up to a 96-hour emergency situation coverage.

○ No

Please explain.

12. Please list the requested data in each category in *Table 1 – Top Drug Claims Data Reviewed by the DUR Board* below.

    Column 1 – Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level

    Column 2 – Top 10 PA Requests by Drug Class

    Column 3 – Top 5 Claim Denial Reasons (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, and Age Edits)

    Column 4 – Top 10 Drug Names by Amount Paid (Generic Names), report at generic ingredient level

    Column 5 – From Data in column 4, determine the Percentage of Total Drug Spend

    Column 6 – Top 10 Drug Names by Claim Count (Generic Names), report at generic ingredient level

    Column 7 – From Data in Column 6, determine the Percentage of Total Claims

Table 1: Top Drug Claims Data Reviewed by the DUR Board

Column 1 **Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level**	Column 2 **Top 10 Prior Authorization (PA) Requests by Drug Class**	Column 3 **Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications and Age Edits)**	Column 4 **Top 10 Drug Names by Amount Paid, report at generic ingredient level**	Column 5 **% of Total Spent for Drugs by Amount Paid (From data in Column 4, Determine the % of total drug spend)**	Column 6 **Top 10 Drug Names by Claim Count, report at generic ingredient level**	Column 7 **Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)**
Oxycodone HCl Tabs	Analgesics	product/service not covered - plan/benefit exclusion	Antihemophilic Factor RAHF-PFM	6.96 %	Albuterol Sulfate/ipratropium bromide	2.59 %
Guanfacine HCl Tabs (ADHD) Tb24	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	dur reject error	Coagulation Factor VIIa (Recombinant)	4.05 %	Hydrocodone-Acetaminophen	2.12 %
Amphetamine-Dextroamphetamine Cap SR 24hr	Antiasthmatic and Bronchodilator Agents	prior authorization required	Paliperidone Palmitate	2.12 %	Gabapentin	2.12 %
Omeprazole CPDR	Ulcer Drugs/Antispasmodics/Anticholinergi	plan limitations exceeded	Lurasidone HCl	1.72 %	Atorvastatin Calcium	1.71 %
Lisdexamfetamine Dimesylate Caps	Dermatologicals	Missing/Invalid Quantity Dispensed	Antihemophilic Factor (Recombinant)	1.72 %	Ibuprofen	1.6 %
Zolpidem Tartrate Tabs	Hypnotics/Sedatives/Sleep Disorder Agents		adalimumab	1.56 %	lisinopril	1.27 %
Methylphenidate HCl TBCR	Antipsychotics/Antimanic Agents		Insulin Glargine	1.23 %	Quetiapine FumarateTrazodone HCl	1.27 %
Morphine Sulfate TBCR	Antidepressants		Albuterol Sulfate/ipratropium bromide	1.22 %	Trazodone HCl	1.23 %
Buprenorphine HCl-Naloxone HCl Dihydrate Film	Anticonvulsants		Sofosbuvir-Velpatasvir	1.13 %	Ondansetron HCl	1.21 %
Albuterol Sulfate Aers	Gastrointestinal Agents - Misc.		Aripiprazole	0.99 %	Levothyroxine Sodium	1.2 %

13. Section 1927(g)(A) of the Social Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in your state has responsibility for monitoring compliance with the oral counseling requirement? Check all that apply:

- ☐ Medicaid agency
- ☒ State Board of Pharmacy
- ☐ Other

Please explain.

14. **Summary 1 – Pharmacy Oral Counseling Compliance**

Summary 1 Pharmacy Oral Counseling Compliance reports the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid Agency, the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid Agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the Omnibus Budget Reduction Act (OBRA) of 1990 prospective DUR requirement. This report details state efforts to monitor pharmacy compliance with the oral counseling requirement and should describe in detail, utilizing the text box below, the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.

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

III. **RETROSPECTIVE DUR (RetroDUR)**

1. Indicate the type of vendor that performed your RetroDUR activities during the time period covered by this report.

- (●) Company
- ( ) Academic Institution
- ( ) Other Institution

a. Identify, by name, your RetroDUR vendor.

OptumRx

b. Is the RetroDUR vendor also the MMIS fiscal agent?

- ( ) Yes
- (●) No

c. Is the RetroDUR vendor also the developer/supplier of your retrospective DUR criteria?

- (●) Yes
- ( ) No

If *"No,"* please explain.

2. Who reviews and approves the RetroDUR criteria?

☐ State DUR Board

☐ Academic Institution

☒ Other

Please explain.

The DUR Board offers topics and reviews but does not approve the letters and final initiatives.

3. **Summary 2 – Retrospective DUR Educational Outreach**
Summary 2 Retrospective DUR Educational Outreach is a year-end summary report on RetroDUR screening and educational interventions. The year-end summary should be limited to the most prominent **10** problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed below.

The Top Ten Retro-DUR activities for 2019 are as follows:
Diabetics Without a Statin: We identified 202 recipients who receive an anti-diabetic medication without receiving a statin for cholesterol. We received 20 positive responses back.
Opioid Use Disorder Diagnosis and Receiving an Opioid: Recipients who have a diagnosis of opioid use disorder were identified and letters were sent to prescribers if the member also had an opioid filled. There were 86 letters sent and 7 returned.
Zolpidem Utilization: Female recipients who are receiving over 5mg of zolpidem were identified. 131 letters were sent, and 12 responses were received.
Anti-anxiety and Hypnotic Combination in Members Over 65-Years Old: Members over the age of 65 with concurrent fills of an anti-anxiety medication and a hypnotic medication were identified. Letters were sent to 48 prescribers and 3 responses were received.
Hepatitis C treatment Follow-Up: Letters were sent to 28 prescribers asking for follow-up on completed hepatitis-C treatment after completion. Five responses were received.
COPD Compliance: Recipients with a record of admission to urgent care or the emergency department with the primary diagnosis of COPD exacerbation were identified. Letters were sent to prescribers of recipients with sub-optimal therapy. 15 letters were sent, and 2 responses were received.
Top 10 Opioid Prescribers: Based on the DUR Board recommendation, the top ten opioid prescribers by the number of claims were notified by letter of where they rate among their peers. Ten letters were sent, and one response was received.
Buprenorphine and Opioid in Combination: Recipients were evaluated for concurrent use of buprenorphine and an opioid. 65 recipient profiles were reviewed, but no members were found to have concurrent opioids and a buprenorphine product.
High Potency Topical Steroids and Extended Duration: Recipients with consecutive claims for a high potency topical steroid were queried. No recipients with extended consecutive claims were identified.

IV. DUR BOARD ACTIVITY

1. **Summary 3 – DUR Board Activities Report**
   Summary 3 DUR Board Activities Report should be a brief descriptive report on DUR Board activities during the fiscal year reported. Please provide a detailed summary below:

   - Indicate the number of DUR Board meetings held.
   - List additions/deletions to DUR Board approved criteria.
     a. For prospective DUR, list problem type/drug combinations added or deleted.
     b. For retrospective DUR, list therapeutic categories added or deleted.
   - Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens.
   - Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring).

Nevada Medicaid held four meetings between October 1, 2018 and September 30, 2019. For prospective DUR and retrospective DUR, the DUR Board can recommend updates and changes to initiatives, policies and education. The OptumRx DUR Pharmacist provides education and resources to providers through retrospective DUR initiatives. The DUR Board did not establish new policies as a result of prospective or retrospective DUR screenings.
Below is a summary of each meeting.

October 18, 2018
Clinical Presentations and Board Discussion:
Immunomodulator Drugs; Addition of criteria for Ilumya
Opioids Specific to Recipients Under 18 Years of Age; decrease day supply to three days for recipients under age 18
Calcitonin Gene-Related Peptide Receptor (CGRP) Inhibitors; addition of new criteria
Board Reports:
High Dollar Claims (Claims over $10,000)
Top Opioid Utilization by Prescriber and Member
Antibiotic Utilization
Oncology Medication Utilization

January 24, 2019
Clinical Presentations and Board Discussion:
Anti-Neoplastic Agents; addition of criteria for all oral anti-neoplastic agents
Inhaled Short-Acting Beta Agonists; quantity limit of two units per month added
Compound Medications; criteria revised to include all outpatient compounded medications
Sacubitril/Valsartan (Entresto); criteria removed
Cannabidiol (Epidiolex); addition of new criteria
Medications for the Treatment of Pulmonary Arterial Hypertension; added diagnosis

2. Does your state have an approved Medication Therapy Management Program?

○ Yes
◉ No

If the answer to question 2 is "Yes," please continue.

a. Have you performed an analysis of the program's effectiveness?

○ Yes
Please provide a brief summary of your findings.

○ No

b. Is your DUR Board involved with this program?

○ Yes
○ No

If the answer to question 2 is "No," are you planning to develop and implement a program?

◉ Yes
○ No

V. PHYSICIAN ADMINISTERED DRUGS

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

1. ProDUR?

   ◉ Yes

   ○ No

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

   ○ Yes

   ○ No

2. RetroDUR?

   ◉ Yes

   ○ No

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

   ○ Yes

   ○ No

VI. GENERIC POLICY AND UTILIZATION DATA

1. **Summary 4 – Generic Drug Substitution Policies**
   Summary 4 Generic Drug Substitution Policies summarizes factors that could affect your generic utilization percentage. Please explain and provide details below.

NRS 639.2583 requires that if a practitioner has prescribed a drug by brand name and the practitioner has not indicated that a substitution is prohibited, the pharmacist who fills or refills the prescription shall dispense, in substitution, another drug which is available to him or her if the other drug is a) less expensive than the drug prescribed by brand name; b) is biologically equivalent to the drug prescribed by brand name; c) has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the drug prescribed by brand name; and d) is of the same generic type as the drug prescribed by brand name. If the pharmacist has available to him or her more than one drug that may be substituted for the drug prescribed by brand name, the pharmacist shall dispense, in substitution, the least expensive of the drugs that are

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

   ◉ Yes
   ○ No

   If "Yes," check all that apply.

   - ☒ Require that a MedWatch Form be submitted
   - ☒ Require the medical reason(s) for override accompany the prescription
   - ☒ Prior authorization is required
   - ☐ Other
     Please explain.

Complete Table 2 – Generic Drug Utilization Data and answer Questions 3 and 4 below.

Computation Instructions

KEY

> **Single Source (S)** – Drugs having an FDA New Drug Application (NDA), and there are no generic alternatives available on the market.
>
> **Non-Innovator Multiple-Source (N)** – Drugs that have an FDA Abbreviated New Drug Application (ANDA), and generic alternatives exist on the market
>
> **Innovator Multiple-Source (I)** – Drugs which have an NDA and no longer have patent exclusivity.

1. **Generic Utilization Percentage:** To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula:

   $$N \div (S + N + I) \times 100 = \text{Generic Utilization Percentage}$$

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

   $$\$N \div (\$S + \$N + \$I) \times 100 = \text{Generic Expenditure Percentage}$$

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I, which can be found at Medicaid.gov (Click on the link "an NDC and Drug Category file [ZIP]," then open the Medicaid Drug Product File 4th Qtr 2019 Excel file).

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

Table 2: Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	387,312	2,225,496	72,068
Total Reimbursement Amount Less Co-Pay	288,072,796.23	44,337,119.66	17,397,802.36

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

   Number of Generic Claims: 2,225,496

   Total Number of Claims: 2,684,876

   Generic Utilization Percentage: 82.89%

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

   Generic Dollars: $44,337,119.66

   Total Dollars: $349,807,718.25

   Generic Expenditure Percentage: 12.67%

VII. PROGRAM EVALUATION / COST SAVINGS / COST AVOIDANCE

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

   ◉ Yes

   ○ No

   If "Yes," identify, by name and type, the institution that conducted the program evaluation.

   Institution Type

   ◉ Company

   ○ Academic Institution

   ○ Other Institution

   Institution Name

   OptumRx

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

	Data
ProDUR Total Estimated Avoided Costs	281,604,516.91
RetroDUR Total Estimated Avoided Costs	3,010.45
Other Cost Avoidance	0
Grand Total Estimated Avoided Costs	281,607,527.36

3. The Estimated Percent Impact was generated by dividing the Grand Total Estimated Avoided Costs from Question 2 above by the Total Dollar Amount provided in Section VI, Question 4, then multiplying this value by 100.

   Estimated Percent Impact: 80.5 %

4. **Summary 5 – Cost Savings/Cost Avoidance Methodology**
Summary 5 Cost Savings/Cost Avoidance Methodology includes program evaluations/cost savings estimates prepared by state or contractor. Please provide detailed summary below.

OptumRx calculates the ProDUR savings by summing the amounts on claims either reversed or denied due to a ProDUR edit. We understand these numbers will be inflated as there is no way to track if the medication was later filled again after consulting with the prescriber or patient or taken to a different pharmacy.
The retro-DUR cost avoidance is the reduction of pharmacy paid amount for opioids after notifying the top 10 opioid prescribers. The spend decreased from $345,705 to $342,694 from first quarter 2019 to second quarter 2019 after the letters were sent creating a savings of $3,010.

VIII. FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

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

- (●) Yes
- ( ) No

If "Yes," what actions does this process initiate? Check **all** that apply:

- [ ] Deny claims and require prior authorization
- [x] Refer to Lock-In Program
- [x] Refer to Program Integrity Unit/Surveillance Utilization Review (SURS unit)
- [ ] Refer to Office of Inspector General
- [ ] Other

Please explain.

2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?

   ◉ Yes

   ○ No

   If the answer to question 2 is "Yes," please continue.

   a. What criteria does your state use to identify candidates for Lock-In? Check **all** that apply:

      ☒ Number of controlled substances (CS)

      ☒ Different prescribers of CS

      ☒ Multiple pharmacies

      ☐ Number days' supply of CS

      ☐ Exclusivity of short acting opioids

      ☒ Multiple ER visits

      ☒ PDMP data

      ☒ Other

      Please explain.

      If the recipient has been diagnosed with a drug dependency related condition or if the dispensed quantity per prescription of controlled substances appears excessive by the clinical review team; or the recipient has other noted drug seeking behaviors.

b. Do you have the capability to restrict the beneficiary to:

i) Prescriber only

- (●) Yes
- ( ) No

ii) Pharmacy only

- (●) Yes
- ( ) No

iii) Prescriber and pharmacy

- (●) Yes
- ( ) No

c. What is the usual Lock-In time period?

- ( ) 12 months
- ( ) 18 months
- ( ) 24 months
- (●) As determined by the state on a case by case basis
- ( ) Lock-in time period is based on number of offences
- ( ) Other

Please explain.

d. On average, what percentage of the FFS population is in Lock-In status annually?

0.44 %

e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review as part of Attachment 5.

$ 1,506,335

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

○ Yes

What actions does this process initiate? Check all that apply:

☐ Deny claims written by this prescriber
☐ Refer to Program Integrity Unit
☐ Refer to the appropriate Medical Board
☐ Other
Please explain.

◉ No

Please explain

Currently, the program does not include regular reviews to identify prescribers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board and regular reports are reviewed for other initiatives; any anomalies are reported to the SUR unit for investigation.

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

○ Yes

What actions does this process initiate? Check all that apply:

☐ Deny claim
☐ Refer to Program Integrity Unit
☐ Refer to Board of Pharmacy
☐ Other

Please explain.

◉ No

Please explain.

Currently, the program does not include regular reviews to identify prescribers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board and regular reports are reviewed for other initiatives; any anomalies are reported to the SUR unit for investigation.

5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by **beneficiaries**?

   ○ Yes

   Please explain your program for fraud, waste, or abuse of non-controlled substances.

   ◉ No

   Please explain.

   Currently, the program does not include regular reviews to identify pharmacy providers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board and regular reports are reviewed for other initiatives; any anomalies are reported to the SUR unit for investigation.

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Does your state have a Prescription Drug Monitoring Program (PDMP)?

   ◉ Yes

   ○ No

   If the answer to question 1 is "Yes," please continue with a, b, and c.

   a. Does your agency have the ability to query the state's PDMP database?

      ○ Yes, we receive PDMP data

      ◉ Yes, we have access to the database

      ○ No

If the answer to sub-question 1 a is "Yes," please continue.

i) Please explain how the state applies this information to control fraud and abuse.

A query may be used during a Lock-In evaluation of a recipient.

ii) Do you also have access to Border States' PDMP information?

- (●) Yes
- ( ) No

iii) Do you also have PDMP data (i.e. outside of MMIS, such as a controlled substance that was paid for by using cash) integrated into your POS edits?

- ( ) Yes
- (●) No

b. Do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing controlled substances?

- ( ) Yes
- (●) No

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

- (●) Yes

  Please explain the barriers (i.e. lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).

  Only one State employee is allowed access and none of the Managed Care Organizations have access. The Nevada PDMP only includes data on controlled substances, not all drugs. There are inconsistencies and inaccuracies in the way that data is entered by the pharmacist filling the prescription. For example, a pharmacist enters in coupon as payment method, then when contacted and asked about the coupon, the pharmacy

- ( ) No

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

   ○ Yes
   Please explain.

   ◉ No

C. PAIN MANAGEMENT CONTROLS

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

   ○ Yes

   ◉ No

   If the answer to question 1 is "Yes," please continue.

   a. Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?

      ○ Yes

      ○ No

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

If "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

- ○ Yes
- ○ No

If *"No,"* please explain.

b. Do you apply this DEA file to your RetroDUR reviews?

- ○ Yes

Please explain how it is applied.

- ○ No

2. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?

- ○ Yes
- ◉ No

Please explain why you do not have a measure in place to either manage or monitor the prescribing of methadone for pain management.

Methadone is non-preferred in the opioid drug class on the Nevada PDL.

D. OPIOIDS

1. Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription?

- (●) Yes, for all opioids
- ( ) Yes, for some opioids
- ( ) No, for all opioids

Please explain answer above

All opioids are limited to 60 morphine equivalents, a max of seven-day supply and a maximum of 13 fills per rolling 12 months for adults. For children under 18 years of age, the day supply is limited to three.

If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue.

a. Is there more than one quantity limit for the various opioids?

- ( ) Yes

Please explain.

- (●) No

b. What is the maximum number of days' supply allowed for an initial opioid prescription?

7 # of days

c. Does this days' supply limit apply to opioid prescriptions?

- (●) Yes, for all opioids
- ( ) Yes, for some opioids
- ( ) No

Please explain.

2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?

- (●) Yes

  What is your maximum days' supply per prescription limitation?

  - ( ) 30 day supply
  - ( ) 34 day supply
  - ( ) 90 day supply
  - (●) Other
    Please explain.

    All fills are limited to seven-day supply without obtaining prior authorization.

- ( ) No

  Please explain.

3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids?

- (●) Yes
- ( ) No

If "Yes," what is your maximum days' supply per prescription limitation?

- ( ) 30 day supply
- ( ) 34 day supply
- ( ) 90 day supply
- (●) Other

Please explain.

Recipients can get up-to 34-day supply with an approved prior authorization (PA). A recipient limited to a seven-day supply without a PA.

If "No," please explain.

4. Do you have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?

- (●) Yes
- ( ) No

If "Yes," check all that apply:

- [ ] Pharmacist override
- [x] Deny claim and require PA
- [ ] Intervention letters
- [x] Morphine Milligram Equivalent (MME) daily dose program
- [ ] Step therapy or clinical criteria
- [x] Requirement that patient has a pain management contract or Patient-Provider agreement
- [ ] Requirement that prescriber has an opioid treatment plan for patients
- [ ] Require documentation of urine drug screening results
- [ ] Require diagnosis
- [ ] Require PDMP checks
- [ ] Workgroups to address opioids
- [x] Other

Please provide details on these opioid prescribing controls in place.

All of the following criteria must be met in order for a recipient to exceed the number of seven-day prescriptions, to exceed the seven-day limit or to exceed the 60 mg morphine equivalents or less per day; if the recipient has chronic pain or requires extended opioid therapy and is under the supervision of a licensed prescriber, if the pain cannot be controlled through the use of non-opioid therapy (acetaminophen, NSAIDs, antidepressants,

If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.

5. Do you have POS edits to monitor duplicate therapy of opioid prescriptions?

- (●) Yes
- ( ) No

Please explain.

Pro-DUR edits are in place to monitor duplicate therapy.

6. Do you have POS edits to monitor early refills of opioid prescriptions dispensed?

- (●) Yes
- ( ) No

Please explain.

Refill limits are set to 90% of previous fill must be used.

7. Do you have comprehensive claims review automated retrospective process to monitor opioid prescriptions exceeding these state limitations?

- ( ) Yes, please explain in detail scope and nature of these retrospective reviews
- (●) No

Please explain.

RetroDUR is a manual review process and opioid reports are presented to the DUR Board.

8. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and benzodiazepines being used concurrently?

- ○ Yes, POS edits only
- ○ Yes, retrospective reviews only
- ◉ Yes, both POS edits and retrospective reviews

Please explain in detail scope and nature of reviews and edits.

ProDUR edits are in place to warn of combination of opioids and benzodiazepines. The RetroDUR program includes initiatives to address the combination of opioids and benzodiazepines.

- ○ No

Please explain.

9. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and sedatives being used concurrently?

- ◉ Yes, POS edits only
- ○ Yes, retrospective reviews only
- ○ Yes, both POS edits and retrospective reviews

Please explain in detail scope and nature of reviews and edits.

ProDUR edits are in place to warn of the combination of opioids and sedatives being used concurrently.

- ○ No

Please explain.

10. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and antipsychotics being used concurrently?

- ○ Yes, POS edits only
- ○ Yes, retrospective reviews only
- ◉ Yes, both POS edits and retrospective reviews

Please explain in detail scope and nature of reviews and edits.

POS claims are edited with ProDUR edits set to warn pharmacists of the combination of opioids and antipsychotics. RetroDUR activities include letters and information to prescribers for the combination of opioids and antipsychotics.

- ○ No

Please explain.

11. Do you have POS safety edits or perform RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?

- ○ Yes, POS edits only
- ◉ Yes, retrospective reviews only
- ○ Yes, both POS edits and retrospective reviews
- ○ No

If "Yes," retrospective reviews are performed, please indicate how often.

- ○ Monthly
- ○ Quarterly
- ○ Semi-Annually
- ○ Annually
- ◉ Ad hoc
- ○ Other
  Please specify.

Please explain nature and scope of edits, reviews and/or provider education reviews performed.

RetroDUR activities include letters and information to prescribers providing for members with opioid use disorder and who are receiving an opioid.

If "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?

- ○ Yes
- ○ No

Please explain.

12. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?

- ◉ Yes
- ○ No

If "Yes," please check all that apply:

- ☒ Your state Medicaid agency refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain.
- ☐ Other guidelines.

  Please identify the "other" guidelines.

- ☐ No guidelines are offered.

  Please explain why no guidelines are offered.

13. Do you have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?

- (●) Yes

  Please explain.

  The preferred drug list contains a drug class specific to abuse deterrent opioids. Members do not have to try a non-abuse deterrent opioid prior to gaining access to abuse deterrent opioids.

- ( ) No

E. MORPHINE MILLIGRAM EQUIVALENT (MME) DAILY DOSE

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

- (●) Yes
- ( ) No

If "Yes," please continue.

a. What is your maximum morphine equivalent daily dose limit in milligrams?

- ( ) 50 MME
- ( ) 70 MME
- ( ) 80 MME
- ( ) 90 MME
- ( ) 100 MME
- ( ) 120 MME
- ( ) 200 MME
- (●) Other 60 mg per day

b. Please explain nature and scope of dose limit.

The MME limit applies to all oral opioid products.

If "No," please explain the measure or program you utilize.

2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?

   - (●) Yes
   - ( ) No

   If "Yes," please continue.

   a. Please name the developer of the calculator:

      - (●) CDC
      - ( ) Academic Institution
      - ( ) Other

        Please specify.

   b. How is the information disseminated? Check all that apply:

      - [x] Website
      - [x] Provider notice
      - [ ] Educational seminar
      - [ ] Other

        Please explain.

3. Do you have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?

   - (●) Yes
   - ( ) No

   If "Yes," do you require prior authorization if the MME limit is exceeded?

   - (●) Yes
   - ( ) No

4. Do you have automated retrospective claim reviews to monitor total daily dose (MME) of opioid prescriptions dispensed?

- ○ Yes
- ◉ No

Please explain.

The retrospective claim review is a manual review process through the retroDUR program and DUR meeting presentations.

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER (OUD)

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

- ◉ Yes
- ○ No

If "Yes," please specify the total mg/day:

- ○ 12 mg
- ○ 16 mg
- ◉ 24 mg
- ○ 32 mg
- ○ Other

Please explain.

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

- ○ 3 months or less
- ○ 6 months
- ○ 12 months
- ○ 24 months
- ◉ No limit
- ○ Other
  Please explain.

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

- ○ Yes
- ◉ No

If "Yes," please continue.

a. What is your reduced (maintenance) dosage?

- ○ 8 mg
- ○ 12 mg
- ○ 16 mg
- ○ Other
  Please explain.

b. What are your limitations on the allowable length of the reduced dosage treatment?

- ○ 6 months
- ○ 12 months
- ○ No limit
- ○ Other

Please explain.

4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?

- ◉ Yes
- ○ No

5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?

- ○ Yes
- ◉ No
- ○ Other

Please explain.

If "Yes," can the POS pharmacist override the edit?

- ○ Yes
- ○ No

6. Do you have at least one naloxone opioid overdose product available without prior authorization?

   - (●) Yes
   - ( ) No

7. Do you retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?

   - (●) Yes
   - ( ) No

   Please explain.

   RetroDUR activities include review of high-dose opioids without naloxone rescue.

8. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?

   - (●) Yes, State Board of Professional Regulations/Board of Pharmacy/ Board of Medicine and/or State Medicaid agency under protocol
   - ( ) Yes, prescribed independently
   - ( ) No

9. Does your state agency cover methadone for a substance use disorder (i.e. Methadone Treatment Center)?

   - (●) Yes
   - ( ) No

G. ANTIPSYCHOTICS /STIMULANTS

ANTIPSYCHOTICS

1. Do you currently have restrictions in place to limit the quantity of antipsychotics?

   - (●) Yes
   - ( ) No

   Please explain.

   Children under age 18 years-old are allowed one antipsychotic without prior authorization.

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

   - (●) Yes
   - ( ) No

   If "Yes," please continue.

   a. Do you either manage or monitor:

      - ( ) Only children in foster care
      - (●) All children
      - ( ) Other

        Please explain.

b. Do you have edits in place to monitor (check all that apply):

- [x] Child's age
- [ ] Dosage
- [x] Indication
- [x] Polypharmacy
- [ ] Other

Please explain.

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

Recipients under 18 years old are limited to a single anti-psychotic without PA. Children under 18 years of age are allowed one product from three of the following classes (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant or benzodiazepine) without prior authorization. The fourth medication requires prior authorization and two or more medications within the same class require prior authorization. All antipsychotics for children under six

If "No," do you plan on implementing a program in the future?

- ○ Yes

When do you plan on implementing a program?

- ○ No

Please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

STIMULANTS

3. Do you currently have restrictions in place to limit the quantity of stimulants?

- (●) Yes
- ( ) No

4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?

- (●) Yes
- ( ) No

If "Yes," please continue.

a. Do you either manage or monitor:

- ( ) Only children in foster care
- (●) All children
- ( ) Other

Please explain.

b. Do you have edits in place to monitor (check all that apply):

- [x] Child's age
- [x] Dosage
- [x] Indication
- [ ] Polypharmacy
- [ ] Other

Please explain.

c. Please briefly explain the specifics of your documented stimulant monitoring program(s).

Prior authorization is required for all stimulant use for children. More than one agent including more than one long-acting agent requires prior authorization and clinical justification.

If "No," do you plan on implementing a program in the future?

○ Yes

When do you plan on implementing a program?

○ No

Please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

IX. INNOVATIVE PRACTICES

1. Summary 6 – Innovative Practices

Summary 6 - Innovative Practices should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing). Please describe in detailed narrative below any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs (i.e., disease management, academic detailing, automated prior authorizations, continuing education programs).

The Nevada Medicaid Drug Use Review Board continually evolves in order to meet the needs of the recipients while making the practice of medicine fair and efficient for providers. In order to optimize time and the effectiveness of the board, the following lists some of the innovative practices of the Nevada Medicaid Drug Use Review Board.
In a further attempt to quell opioid use in the Nevada Medicaid population, the Board voted during the October 18, 2018 meeting to reduce the max day supply of opioids in children to a three-day supply. Members under the age of 18 are able to fill up to 13 three-day prescriptions in any rolling 12-month period for prescriptions of 60 morphine milligram equivalent (MME) or less per day without prior authorization. Prior authorization requires the recipient have chronic pain or requires an extended opioid therapy, is under the supervision of a licensed prescriber, the pain cannot be controlled through the use of non-opioid therapy, the lowest effective dose is requested and a pain contract is on file.
During the January 24, 2019 DUR Board Meeting, the Board elected to adopt prior

X. E-PRESCRIBING

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

   ◉ Yes

   ○ No

   If "Yes," do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

   ◉ Yes

   Please explain the evaluation methodology in Summary 7.

   Summary 7 - E-Prescribing Activity should explain the evaluation methodology utilized in evaluate the effectiveness of providing drug information and medication history prior to prescribing. Describe below plans/accomplishments in the area of e-prescribing. Include any evaluation of the effectiveness of this technology (i.e., number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).

   As of September 2019, approximately 59% of all prescriptions are transmitted through an ePrescribing platform. This trend continues to grow into FFY2020. As of September 2019, approximately 40% of prescribers have adopted an ePrescribing tool. There were a total of 3,024,742 eligibility checks and a total of 3,784,107 medication history transaction requests between October 1, 2018 and September 30, 2019. Cost-savings evaluation was not performed for this period. In FFY20, an ePA tool should be available to providers. This tool works

   ○ No

   If "No," are you planning to develop this capability?

   ○ Yes

   ○ No

   Please explain

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

   - (●) Yes
   - ( ) No

XI. MANAGED CARE ORGANIATIONS (MCOs)

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

   3

   If "Zero" or "None", please skip the rest of this section.

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

   - ( ) Yes
   - (●) No
   - ( ) Partial

     Please specify the drug categories that are carved out.

3. Does the state set requirements for the MCO's pharmacy benefit (e.g. same PDL, same ProDUR/RetroDUR)?

   - ( ) Yes
   - (●) No

   If "Yes," please continue.

   a. Please check all requirements that apply below:

      - [ ] Formulary Reviews
      - [ ] Same PDL
      - [ ] Same ProDUR
      - [ ] Same RetroDUR
      - [ ] No state PDL

b. Please briefly explain your policy.

If "No," do you plan to set standards in the future?

- (●) Yes
- ( ) No

Please Explain

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

- (●) Yes
- ( ) No

Please explain.

XII. EXECUTIVE REPORT

1. **Summary 8 - Executive Report** should provide a brief overview of your program. It should describe 2019 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.

The Drug Use Review Board (DUR) is a requirement of the Social Security Act, Section 1927 and operates in accordance with Nevada Medicaid Services Manual, Chapter 1200, Prescribed Drugs, and Nevada Medicaid Operations Manual Chapter 1200.
The DUR Board consists of no less than five members and no more than ten members appointed by the State Director of Health and Human Resources. Members must be licensed to practice in the State of Nevada and either an actively practicing physician or an actively practicing pharmacist.
The DUR Board meets quarterly to monitor drugs for: therapeutic appropriateness, over or under-utilization, therapeutic duplications, drug-disease contraindications and quality care. The DUR Board does this by establishing prior authorization and quantity limits to certain drugs/drug classes based on utilization data, experience, and