Pharmacy & Therapeutics Committee Annual Report
October 2021-September 2022

Executive Summary

The 11-member Pharmacy and Therapeutics (P&T) Committee is responsible for advising the Oregon Health Authority (OHA) on the implementation of the fee-for-service (FFS) retrospective and prospective programs and on the Practitioner-Managed Prescription Drug Plan (PMPDP) which apply to carveout medications for all ~1.3M OHP members and all medications for the approximately 113,000 FFS members. OHA reimbursed pharmacies $196,985,029 during FFY 2022 and the total cost avoidance for the P&T-associated programs resulting from the P&T Committee's recommendations were calculated to be $24,341,538. These savings were garnered through Drug Use Review (DUR) activities; Preferred Drug List (PDL) administration; and utilization management such as prior authorization criteria and quantity limits. Details of the P&T recommendations and these highly successful programs are discussed in detail in the following annual report.

Acronyms

CMS – Centers for Medicare & Medicaid Services

DERP – Drug Effectiveness Review Project

DUR – Drug Use Review

DURM – Drug Use Research & Management Program

FDB – First Databank

FFS – Fee-for-Service

FFY – Federal Fiscal Year

MMIS – Medicaid Management Information Systems

OAR – Oregon Administrative Rules

OHA – Oregon Health Authority

P&T – Pharmacy & Therapeutics Committee

PA – Prior Authorization

PAD – Practitioner Administered Drug

PDL – Preferred Drug List

PMPDP – Practitioner-Managed Prescription Drug Plan

PMPM – Per Member Per Month

POS – Point of Sale

ProDUR – Prospective Drug Use Review

QL – Quantity Limits

RetroDUR – Retrospective Drug Use Review

SR – Supplemental Rebates

SSDC – Sovereign States Drug Consortium

Scope and Purpose

The P&T Committee is subject to multiple reporting requirements. Pursuant to Oregon Revised Statute (ORS 414.382), the P&T Committee is directed to publish an annual report on the activities of the P&T Committee and associated DUR programs, including impacts and savings of those programs. The P&T Committee also serves as the federally mandated DUR Board and is required to report RetroDUR and ProDUR activities, state prescribing habits, and cost savings generated from these programs to CMS annually. This report will restate, summarize and expand upon the CMS Drug Utilization Review Annual Survey.

This report covers the 2022 federal fiscal year (October 1, 2021, through September 30, 2022) and provides an overview of the programs and activities of the P&T Committee; an assessment of the impact of the Committee's interventions, criteria and standards; and an estimate of the cost savings generated as a result of its programs. A complete list of P&T Committee activities, reports, report methodology and related resources are within the appendices.

Not covered in this report are programs that were initiated prior to this reporting period and continue to provide significant financial and clinical benefits. Currently there are 132 drug classes in the FFS preferred drug list affecting roughly 6,918 unique drugs – of which 2,448 are currently preferred - that have been reviewed by the P&T Committee. Over 144 unique clinical-use criteria have been created and are being maintained. While not detailed in this report, the maintenance of previous utilization controls and impact of past educational initiatives continue to provide quantifiable financial benefits and shape provider behavior beneficial to Medicaid members, the OHA, and the state.

Organizational Structure

Consistent with ORS 414.353 and Section 1927 of the Social Security Act, the P&T Committee is made up of five Oregon-licensed and actively practicing physicians, four Oregon-licensed and actively practicing pharmacists and two individuals who are not physicians or pharmacists. The P&T Committee is responsible for advising the OHA on the development and implementation of the criteria and standards used for the Medicaid FFS RetroDUR program; ProDUR program; and the PMPDP, also known as the FFS PDL.

There are several contractors involved with the P&T Committees' activities. The Oregon State University College of Pharmacy's DURM program provides staff support for the P&T Committee. DURM develops the evidence-based reviews, drug-use evaluations, policy evaluations and PDL analyses which inform the P&T Committee recommendations. All of the P&T materials are made available to the public on the DURM website where educational newsletters are also published and which were downloaded roughly 36,093 times in 2021. DURM also proposes PA criteria and assists with PDL development and maintenance. Gainwell Technologies (Gainwell) administers the state's electronic monitoring system called the MMIS, staffs the call center that responds to PA requests, and invoices for rebates on behalf of OHA. DURM assists Gainwell with implementing the edits and coding necessary to operationalize the P&T Committee recommendations that have been approved by OHA.

Finally, OHA is a member of two groups that perform additional services that are integral to P&T Committee and DUR activities. The Sovereign State Drug Consortium (SSDC) is a non-profit, multi-state, Medicaid purchasing pool that negotiates supplemental rebates with manufacturers on behalf of member states, including Oregon. These supplemental rebate offers are considered by the P&T Committee when making PDL recommendations. OHA is also a member of the Drug Effectiveness Review Project (DERP), which is a collaborative group of state Medicaid agencies that commission high-quality comparative effectiveness reviews. DERP reports are summarized and presented to the P&T Committee by DURM staff.

Evidence Reviews

Reviews of the most recent medical literature are the foundation of the P&T Committee activities. **Table 1** summarizes the body of work that was developed by the OSU College of Pharmacy DURM program and presented to the P&T Committee during the six times the Committee met during this reporting period. A sound review of the published evidence is the starting point for developing utilization controls. The Committee's recommendations—based on reviews of the evidence, drug use evaluations, policy evaluations, and review of confidential pricing—informed the implementation of OHA's retrospective and prospective DUR programs and PDL maintenance (see detail below). Utilization controls such as PA criteria and quantity limits and other conditions of coverage recommended by the P&T Committee are intended to promote use of safe, appropriate, and cost-effective prescription drug therapy. PA criteria are designed to support access to and use of medications as approved by the FDA and

Table 1. *Summary of Reports presented to the Pharmacy and Therapeutics Committee during federal fiscal year 2022.*

Report Type	Number of Reports Presented
Class Reviews, Class Updates & Updates with (New Drug Evaluations)	27 (13)
Drug Use & Policy Evaluations	6
New Drug Evaluations	3
Drug Class Scans	11

are evaluated periodically to ensure they are functioning as intended and not causing any unanticipated harms. Further details about utilization control policies and management are provided in the PDL & Utilization Management section below. Links to the P&T Committee agendas, reports, and recommendations to the OHA can be found in **Appendix A**.

Prospective Drug Use Review (ProDUR) Programs

Section 1927 of the Social Security Act requires Medicaid programs to have a ProDUR program. Utilization controls, an important element of a ProDUR program, represent the first phase of screening for prescription drug claims at the POS. Gainwell is OHA's pharmacy benefit administrator and is responsible for maintaining and processing Medicaid pharmacy claims through the POS system, which interfaces with MMIS. Gainwell, through its contract with FDB, loads information and edits into the claims processing system on a weekly schedule. Before any prescription is filled at the pharmacy, a review of drug therapy is performed by the pharmacist and then submitted electronically to the state's MMIS. The MMIS screens prescription drug claims to identify potential problems based on the alerts detailed in **Appendix B** such as therapeutic duplication, drug interactions, incorrect dosage or duration of treatment, drug allergies, and clinical misuse or abuse. These alerts offer pharmacists additional information and the opportunity to consult with patients and prescribers to optimize care.

Early Refill and Pregnancy/Drug Interaction are the only two ProDUR alerts currently set to deny claims for FFS Medicaid pharmacy claims either when filled before 80% of the calculated days' supply has elapsed or based on a contraindication for select drugs to be avoided during pregnancy. Additional "informational" ProDUR alerts are sent to pharmacies when they process claims, but do not result in denial or require action by the pharmacy. These alerts provide the pharmacy with notification of potential drug therapy problems, which can result in the pharmacy cancelling the prescription and may improve patient care. The cost savings associated with claims that were not dispensed after ProDUR alerts were triggered was $444,572 during FFY 2022. Cost savings were calculated based on claims that were cancelled after the alert and not reprocessed again at a later date. See **Appendix B** for a detailed ProDUR Program Activity summary.

Retrospective Drug Use Review (RetroDUR) Programs

The RetroDUR Program is the second phase of screening prescription drug claims to identify opportunities to improve quality of care and fiscal stewardship after medications have been dispensed to patients. RetroDUR involves ongoing and periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care. RetroDUR programs may be associated with specific drugs or groups of drugs and are designed to implement corrective action when concerning drug utilization patterns are identified. RetroDUR interventions occur after dispensing of medication and are intended to alter future behaviors. Quantification of the success of these programs is less straightforward when compared to ProDUR, Preferred Drugs List, and other utilization controls.

The DURM group has developed several RetroDUR safety net programs. The Late Antipsychotic Refill Safety Net program is one example that targets members with schizophrenia who are non-adherent to routine antipsychotic therapy. This initiative was designed to notify providers when patients on routine therapy for the treatment of schizophrenia had an interruption in medication therapy of more than 15 days and missed a medication refill. Over the year, 227 providers were sent notifications alerting them to the lack of ongoing therapy for 214 of their patients. Claims review over a 90-day period after providers received notification revealed that 105 of these patients ended up filling a prescription for the original antipsychotic and three more filled for a different antipsychotic. Although it is difficult to quantify the clinical impact on outcomes such as reduced emergency department visits, the program reduces the chance a member will go without a needed medication.

Dose optimization programs are RetroDUR programs with more easily quantified benefits. For a variety of reasons, Medicaid members may end up on a drug regimen with an unexpectedly large quantity of low-strength tablets that can be much more expensive and wasteful than optimal dosing. In some cases, medications are available as both tablets and capsules with significant differences in cost. Optimizing the dose or formulation can result in significant savings and can also improve patient experience of care by lowering the number of needed pills. A RetroDUR Dose Optimization program was designed to educate providers of the cost difference and allow the providers to make changes when clinically appropriate.

During the fiscal year, faxes were sent to 717 prescribers asking them to consider prescribing venlafaxine capsules instead of tablets, which is estimated to have saved $140,246. A similar program recommended a change of desvenlafaxine salt formulation, which reached 300 prescribers and was estimated to have saved $244,507. Another change form was sent to 28 prescribers recommending aripiprazole oral tablets instead of rapid dissolve tablets resulting in $94,537 in estimated savings. Faxes were sent to 87 prescribers requesting they consider consolidating the dose of a prescription they had written. This resulted in an additional estimated savings of $41,973 based on the changes to subsequent prescriptions. Savings from dose optimization are inherently conservative as this estimate does not include cumulative cost savings associated with changes in prescribing practices or ongoing use of more cost-effective regimens.

Patient safety is another focus of the RetroDUR program. Some examples incorporated within the RetroDUR program include: Polypharmacy Reviews (OAR 410-121-0033), the Pharmacy Management Program (OAR 410-121-0135) and a safety net program. The Polypharmacy Reviews identify duplicative or unnecessary prescriptions filled by a member and provide an opportunity to notify prescribers with recommendations to consider discontinuing unneeded medications. Over the fiscal year, faxes were sent to 79 prescribers. The Pharmacy Management Program identifies potential fraud or misuse of drugs by a beneficiary, as indicated by members using multiple pharmacies in a short timeframe. The Pharmacy Management Program requires selected beneficiaries to use a single pharmacy to fill all their

prescriptions for up to 12 months, which allows the pharmacy to monitor services being utilized and reduce unnecessary or inappropriate utilization. The safety net program notifies prescribers via fax when dangerous drug combinations have been prescribed—such as opioids and sedatives—and urges them to perform a risk-benefit assessment, check the PDMP, and if appropriate, prescribe naloxone to prevent overdose.

In addition to the DUR programs, educational initiatives were employed to inform and influence prescribing practices to ensure safety and effectiveness. OHA staff published and distributed educational information for prescribers and pharmacists in the form of newsletters, fax notifications and individualized letters regarding the P&T committee activities and the drug use review programs. Faxes inform pharmacies when initiatives and utilization control changes are being implemented and help avoid interruptions in therapy for their patients. Over the fiscal year, nine informational notifications were faxed to all enrolled pharmacies and 26 targeted individual communications were sent to prescribers. Additionally, nine Oregon State Drug Review newsletter were published: http://pharmacy.oregonstate.edu/drug-policy/newsletters

A complete list of RetroDUR activities and number of interventions is available in **Appendix C** and on the P&T Committee website.

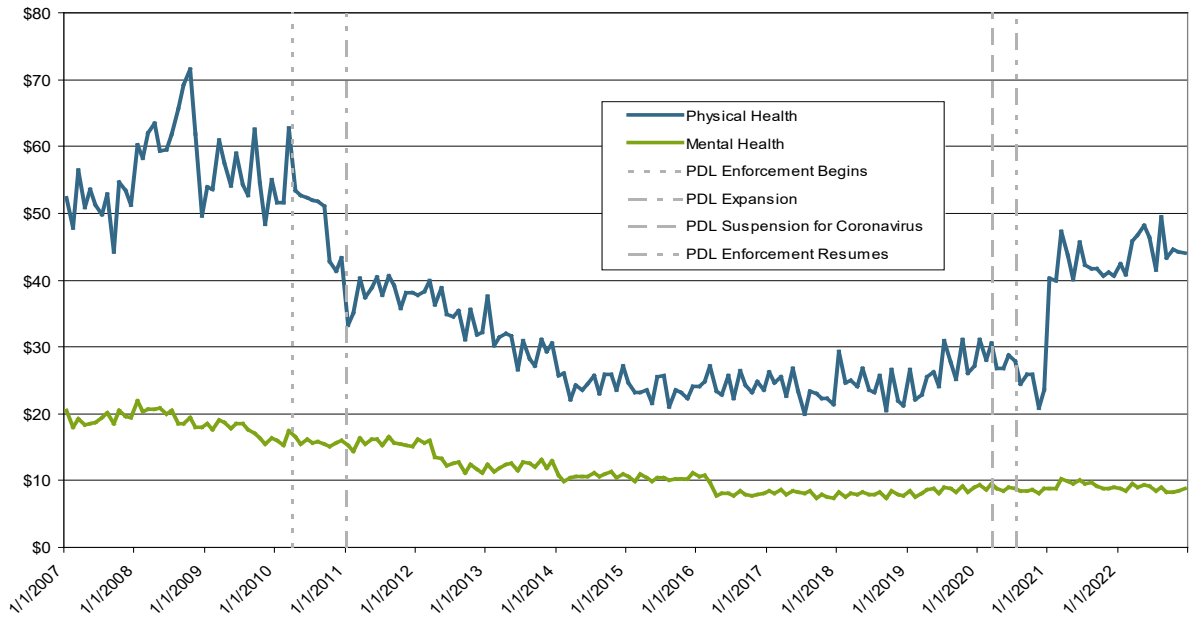
Preferred Drug List & Utilization Management

The FFS Medicaid pharmacy program aims to achieve access to needed pharmaceuticals for Medicaid beneficiaries, administrative ease for providers, safety, and cost effectiveness. In order to manage FFS Medicaid prescription drug use, the OHA uses three primary utilization management tools: the PDL, PA criteria and quantity limits. The PDL contains a list of preferred drugs which have been determined by the P&T Committee to be the most efficacious. Drugs considered non-preferred require prescribers to contact the Oregon Pharmacy Call Center to obtain an authorization. In this way, OHA supports the PDL for physical health drugs. Providers can obtain an authorization by indicating they choose not to switch to the preferred option and confirming the diagnosis for which they are requesting the medication is a funded condition on the Prioritized List of Health Services. Dedicated clinical PA criteria are used for medications the P&T Committee has determined require evaluation beyond simply being preferred or non-preferred. These PA criteria ensure medications are being prescribed for funded conditions, are appropriate for the diagnosis for which they are being prescribed, or that less costly first-line therapies have been tried first. Quantity limits ensure the amounts prescribed are safe, appropriate, and not wasteful. Working together, these three utilization management tools allow OHA to provide safe, effective, and fiscally responsible drug benefits to members.

The PDL developed by the OHA, based on recommendations from the P&T Committee, is created using comparative evidence reviews of the medical literature (See **Table 1** and **Appendix A**). The P&T Committee also considers clinician and public input, as well as appropriate standards of care in the review process. Drugs and drug classes included on the PDL are evaluated by the P&T Committee and recommendations are made to OHA for inclusion or

removal from the PDL based on comparative safety, efficacy, and cost-effectiveness. Drug cost is considered only after clinical recommendations are made and dedicated PA criteria are often developed as new classes are reviewed for inclusion on the PDL. Since implementation of the PDL in 2009 and the expansion of the classes included on the PDL in 2011, the cost per member for physical health drugs has markedly decreased (See **Figure 1**). With administration of the PDL and provider education, prescribers have become familiar with preferred medications and increasingly prescribe cost-effective medications. This is apparent in **Figure 1** below, which demonstrates decreasing pharmacy costs after the PDL was implemented and subsequently expanded. However, it is important to note that other factors (such as demographic changes resulting from Medicaid expansion under the Affordable Care Act) could also play a role in lowering costs. Continued maintenance and expansion of the PDL and development of utilization controls constitutes the bulk of the work performed and presented to the P&T Committee and generates the majority of the savings realized by the OHA.

Figure 1: *Gross Per-Member-Per-Month Prescription Drug Expenditures for Physical and Mental Health Drugs Over the Last Decade*



When making PDL decisions, the P&T Committee considers cost after evidence of safety and efficacy. Confidential federally mandated rebates, which are required of pharmaceutical manufacturers by Section 1927 of the Social Security Act as a condition for Medicaid coverage, are incorporated into the net cost considered by the P&T Committee. In addition, supplemental rebate offers, which manufacturers offer for some medications on top of the CMS federally mandated rebates, are negotiated on behalf of the OHA by the SSDC. Rebates can make the net cost of some brand-name drugs comparatively cost-effective to alternative drugs in some

classes. Supplemental rebates are not required to be offered by manufacturers in order for their medications to be considered for PDL preferred status, but they are considered in the net price. Both supplemental and federally mandated rebates are proprietary and confidential and cannot be disclosed to the public. Over the fiscal year, supplemental rebates collected by the state as a result of implementation and maintenance of the PDL was $46,352,653. The physical health drugs accounted for most of these supplemental rebates totaling $39,292,502.

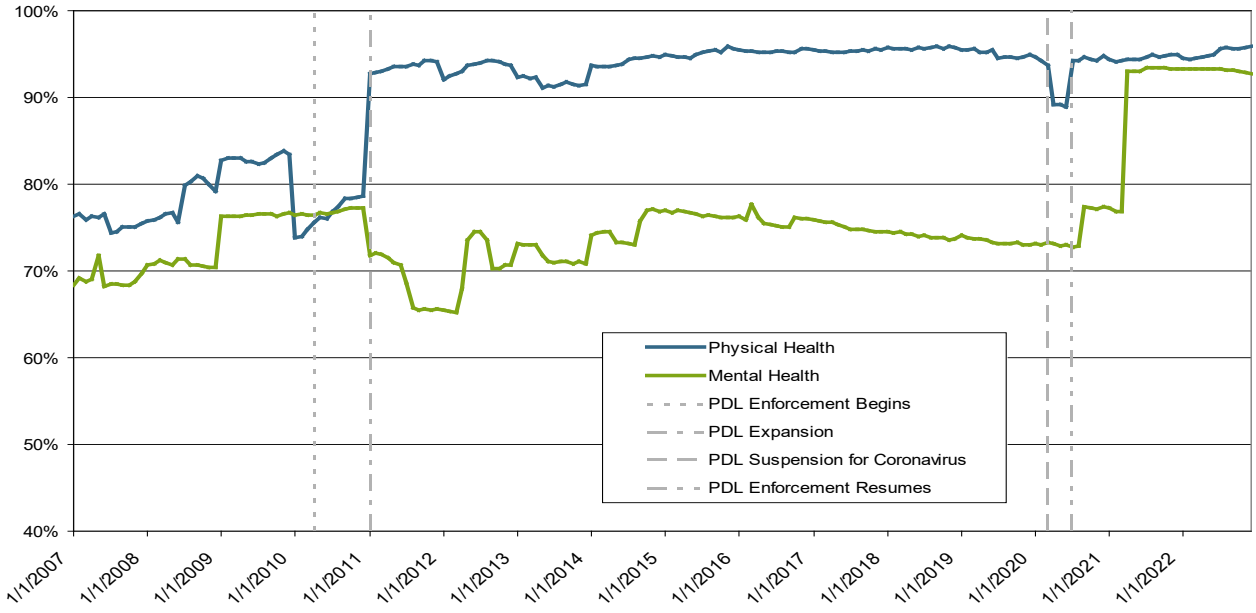
In contrast, the OHA is not permitted to use prior authorization to support the PDL for mental health drugs (chapter 544, Oregon Laws 2019); as a result, the voluntary mental health PDL supplemental rebates accounted for a smaller total at $7,060,151.

As illustrated in **Figure 2**, the ability to require PA for non-preferred physical health drugs resulted in a dramatic increase in the use of preferred agents (from 75% to 95%) - after implementation of the PA for non-preferred agents. This was the driver of the significant savings illustrated in **Figure 1**. In contrast, the use of preferred mental health drugs remained relatively flat (see **Figure 2**) due to a lack of a PA process for non-preferred agents. The dramatic increase in the use of preferred mental health drugs (from 76% to 93%) in April of 2021 was a result of making two frequently prescribed agents preferred.

Over the fiscal year, the Committee's recommendations regarding drugs to be included on the PDL required changes to the PDL status of 46 drug products in the MMIS. Links to the current and historical versions of the PDL that were updated as a result of P&T Committee recommendations can be found in **Appendix D.**

Developing, revising, or removing existing PA criteria is an important role of the Committee. Over the fiscal year the P&T Committee recommended implementing, making substantive changes to, or retiring PA criteria 42 times and made more clerical changes to another 35 criteria. Many additional PA criteria were reviewed to ensure they remain reflective of current best evidence although no changes were made.

Figure 2: *Percent Use of Preferred Drugs for Physical Health Drugs (Enforced) and Mental Health Drugs (Not Enforced)*



The enforcement of quantity limits improves safety and patient outcomes by encouraging appropriate care and minimizing waste. Quantity limits can be used to help prevent overuse and dependence that can occur with sedative hypnotics, narcotic analgesics, benzodiazepines, and certain migraine treatments. They are also used to ensure durations of therapy meet accepted standards of care, such as with certain antibiotics and proton pump inhibitors. Quantity limits can also be used to assure doses do not exceed maximum safe levels. Initiatives to manage use of opioids with quantity limits and help address the ongoing prescription opioid epidemic has been a priority for the OHA and the Committee.

In select cases when brand name medications lose patent protection and generic alternatives are introduced into the market, the generic alternatives initially remain much more expensive than the net cost of the brand equivalent. In these cases, there is an opportunity to mandate continued use of the brand name drug until the cost of the generic alternatives drop. Careful analysis of the federally mandated rebates and comparative net cost of the alternatives is necessary to take advantage of this scenario. Since the selection of the medication being dispensed falls to the pharmacy (and they generally dispense the generic version if available), targeted communication is necessary to ensure pharmacies have adequate stock on hand and understand the departure from the general requirement to dispense generics. Pharmacies also need to have sufficient notice to know when this requirement will end so they can stock and begin to dispense the generic alternatives. Over the 2022 fiscal year, DURM recommended eleven medications for this utilization control. The P&T Committee approved these actions which resulted in $6,308,199 in cost avoidance. In the past, these scenarios have resulted in savings exceeding $15 million for one drug in a single year.

Cost Avoidance Associated with the Utilization Management

Development and implementation of PA criteria and administration of the PDL encourages use of cost-effective therapies and limits costs due to inappropriate prescribing, waste, or abuse. The DURM group created a methodology, as recommended by the P&T Committee, to estimate cost avoidance attributable to PAs and the PDL. The methodology calculates savings by considering the ultimate therapy received by the member and the duration of cost avoidance. When payment for a claim is denied (e.g., denial due to a PA requirement or non-preferred status), all subsequent claims (paid and denied) for the member within the drug class are monitored. Cost avoidance is then calculated based on the initial claim (index event) and the final disposition of therapy within the drug class for a member.

Cost avoidance is categorized into one of several types based on the specific treatment recommendation and scenario. The cost-avoidance categories are deferred, therapeutic duplication, switched, add-on, discontinued, and other. A description of these types of cost avoidance can be found in **Appendix E**. Each cost avoidance type has a distinctive calculation for the duration of cost avoidance and the amount saved, based on the most likely clinical treatment pathway. Factors considered for each cost-avoidance type include: duration of eligibility for the FFS program, enrollment into CCOs; maintenance drug indicator; cost of alternative therapy; and the number of paid and denied claims in the drug class.

The estimate of cost avoided over the fiscal year was $17,067,504 in total drug expenditures by administration of PA criteria, PDL enforcement and quantity limits.

Cost Benefit, Outcomes & Impact Assessment

The cost related to OHA's pharmacy contracts to support the P&T Committee must be accounted for when measuring the cost-benefit analysis of both the ProDUR and RetroDUR programs as well as PDL management.

Gainwell's and DURM's contracts are not solely devoted to the work of the P&T Committee as they provide additional services to OHA. It is impossible to calculate the cost of Gainwell's services that were directly associated with the functions of the P&T Committee. Their contract is expansive and does not separately assign costs specific to P&T Committee functions. However, the portion of the DURM contract that was dedicated to supporting the P&T Committee work and assisting Gainwell with PDL and PA coding was tracked and estimated to be roughly 65% of their effort.

Since the DURM is almost exclusively staffed by pharmacists who provide clinical expertise to the OHA, the cost for their services is paid by 75% federal matching funds and 25% from state funds. Over the fiscal year, approximately $1,049,593 was billed by DURM to OHA for those clinical services, of which $262,398 was state funds, with the remainder being federally funded.

OHA also contracts with OHSU and is a member of the DERP, a collaborative group of state Medicaid agencies that commission high-quality, evidence-based, comparative effectiveness

reviews which are also presented to the P&T Committee. The cost to Oregon to participate in DERP for the fiscal year was $95,500 which is paid with 50% state and 50% matching federal funds.

OHA is a member of the SSDC, which is a CMS-approved, state-administered, multi-state Medicaid supplemental drug rebate pool which negotiates supplemental rebate offers that are considered for PDL placement. Oregon paid $42,998 total funds over the fiscal year to be a member of the SSDC and to take advantage of the supplemental rebates negotiated.

The cost-benefit analysis of the ProDUR and RetroDUR programs should consider the total cost of the program, potential cost savings and avoidance, and the total cost of pharmacy benefits. OHA reimbursed pharmacies $196,985,029 over the fiscal year. Various vendor contracts (with specific calculations for Gainwell Technologies' contributions as described above) cost the state $1,188,091 over the same period to provide services associated with the P&T Committee. These contract costs were approximately 0.6% of the total pharmacy expenditures. The total cost avoidance for the P&T Committee-associated programs was calculated to be $24,341,538, representing approximately 12% of total outpatient pharmacy expenditures. The return on the investment for P&T Committee-associated contracts was more than 20 to 1, demonstrating the value of services provided by all vendors involved.

Appendices

Appendix A – Materials Presented to the Pharmacy and Therapeutics Committee

Documents from October 2021 - September 2022

P &T Meetings

1. **October 07, 2021 - P&T Packet - Recommendations**
2. **December 02, 2021 - P&T Packet - Recommendations**
3. **February 03, 2022 - P&T Packet - Recommendations**
4. **April 07, 2022 - P&T Packet - Recommendations**
5. **June 02, 2022 - P&T Packet - Recommendations**
6. **August 04, 2022 - P&T Packet - Recommendations**

Class Reviews & Updates

1. **Alzheimer's Disease**
2. **Antiparasitic agents, Topical**
3. **CGRP Inhibitors**
4. **Oncology**
5. **Pulmonary Hypertension**
6. **Targeted Immune Modulators Class update with Ozanimod PA update**
7. **Drugs for Endometriosis and Uterine Fibroids**
8. **Drugs for Paroxysmal Nocturnal Hemoglobinuria**

9. Glucagon Class Update/New Drug Evaluation
10. Growth Hormones Class Update/New Drug Evaluation
11. Antifungals (oral)
12. Drugs for Pompe Disease
13. Glucocorticoids (oral)
14. Immunosuppressants (with Lupus focused new drug evaluations)
15. Oncology
16. Oral Fluoroquinolones Class Update
17. ADHD DERP summary
18. Diuretics, Oral
19. Mycobacterium Drugs
20. Therapeutics for Atopic Dermatitis and Inflammatory Skin Conditions
21. TIMs for Asthma
22. Beta-blockers, oral
23. Estrogens
24. Nasal Allergy Inhalers
25. PCSK9 Modulators
26. Sedatives Update with New Drug Eval
27. Thyroid Hormones, oral

Drug Use & Policy Evaluations

1. Pre-exposure Prophylaxis for HIV
2. Palivizumab Policy Update
3. ADHD Drug Use Evaluation
4. Buprenorphine Duration Drug Use Evaluation
5. Buprenorphine Indication Drug Use Evaluation
6. Buprenorphine Polypharmacy Drug Use Evaluation

New Drug Evaluations

1. Orphan Drug
2. Voxzogo (vosoritide) injection
3. Vyvgart (efgartigimod alfa-fcab) injection

Scans

1. Anticholinergics, Inhaled
2. Antiepileptics (non-injectable)
3. Hepatitis C, Direct-Acting Antivirals
4. Bile Therapy Scan
5. Inhaled Drugs for Cystic Fibrosis
6. Antipsychotics (Parenteral)
7. Inhibitors of the Renin-Angiotensin-Aldosterone System (RAAS)
8. Fabry Disease Scan
9. Hepatitis C DAA Policy Proposal

10. **Sickle Cell Disease Scan**
11. **Vitiligo Literature Scan**

Newsletters

1. **Nov 2021 - Anti-SARS-CoV-2 Therapeutics can Effectively Treat, Prevent COVID-19 Infection**
2. **Dec 2021 - A PEP Talk on PrEP-ing for HIV Prevention**
3. **Jan 2022 - Second-Generation Antipsychotic Use in Children and Adolescents**
4. **Mar 2022 - Updated 2021 Treatment Guidelines for Sexually Transmitted Infections**
5. **Apr 2022 - Asthma Guidance Update with a Focus on Changes for Managing Patients with Mild Asthma**
6. **May 2022 - Population Trends in the Use of Migraine Preventative Treatments**
7. **Jul 2022 - Antimicrobial Stewardship**
8. **Aug 2022 - An Update in Lipid Lowering Therapies**
9. **Sep 2022 - COVID-19 Vaccine Bivalent Boosters**

Appendix B – ProDUR Summary

The ProDUR review includes screening for potential drug therapy problems based on the following alerts:

DA Drug/Allergy Interaction: Triggers if there is an association between an ingredient and an allergy recorded in the recipient profile.

DC Inferred Disease Interaction: Triggers if there is a drug on the recipient's profile that is indicated for a disease state that interacts with the drug being filled.

DD Drug to Drug Interaction: Triggers if there is an interaction between the drug being filled and another drug on the recipient's profile.

ER Early Refill (Overutilization): Triggers if the drug being billed is too early based on previous billing and day supply. Allow filling when 80% of previous fill has been used.

HD High Dose: Triggers if the drug being billed, based on billed day supply, exceeds the maximum recommended daily quantity limit

ID Ingredient Duplication: Triggers if the drug being filled has a matching ingredient to another recently filled drug on the recipient's profile.

LD Low Dose: Triggers if the drug being billed, based on billed day supply, is below the minimum recommended daily quantity limit.

LR Late Refill (Underutilization): Triggers if the drug being filled is late in being refilled for the recipient.

MC Drug to Disease Interaction: Triggers if there is a disease Diagnosis (ICD-10) on the recipients claim profile that interacts with the drug being filled.

MX Maximum Duration of Therapy: Triggers if the day supply on the claim is greater than the maximum days value.

PA Pediatric and Geriatric Age Limits: Triggers if the age of the recipient is less than the minimum (pediatric) or greater than the maximum (geriatric) age for the drug being billed.

PG Pregnancy/Drug Interaction: Triggers if the drug being filled is contraindicated for use in pregnancy and the patient profile indicates that the patient may be pregnant.

TD Therapeutic Duplication: Triggers if the class of drug being billed matches the drug class of another recently filled medication on the recipient's profile.

Early Refill and Pregnancy/Drug Interaction are the only two ProDUR alerts set to deny claims for FFS Medicaid pharmacy claims.

Additional ProDUR alerts are sent to pharmacies when they process claims, but do not result in denial or require action by the pharmacy.

Cost Savings Estimates

The Pro-DUR program currently relies on the following alerts for monitoring claims triggered by these alerts and claims that were cancelled after the pharmacy received the ProDUR alert and not reprocessed again at a later date or overridden were assumed to be additional cost savings.

Early Refill Cost Savings Estimates

Starting January 13, 2013, a system enhancement went into production that required pharmacies to enter a Submission Clarification Code each time they were overriding an early refill ProDUR rejection. The accepted codes would help OHA and the P&T Committee to identify the reasons for the early refill. Accepted values in this field were as follows:

3= Vacation supply - The pharmacist is indicating that the cardholder has requested a vacation supply of the medication.
4= Lost prescription - The pharmacist is indicating that the cardholder has requested a replacement of medication that has been lost.
5= Therapy change - The pharmacist is indicating that the physician has determined that a change in therapy was required; either the medication was used faster than expected or a different dosage form is needed, etc.
6= Starter dose - The pharmacist is indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment.
7= Medically necessary - The pharmacist is indicating that this medication has been determined by the physician to be medically necessary.
13=Payer-Recognized Emergency/Disaster Assistance Request-The pharmacist is indicating that an override is needed based on an emergency/disaster situation recognized by the payer.

14=Long Term Care Leave of Absence_- The pharmacist is indicating that the cardholder requires a short-fill of a prescription due to a leave of absence from the Long-Term Care (LTC) facility.
The cost savings due to claims that were not dispensed because of this alert, defined as being cancelled and then not being reprocessed again at a later date, are outlined in the table below.

Early Refill Cost Saving		
Month	**ER Claims Cancelled**	**ER Cost Savings**
October 2021	288	$ 62,177.97
November 2021	46	$ 14,275.51
December 2021	57	$ 15,931.54
January 2022	34	$ 14,372.53
February 2022	30	$ 7,887.25
March 2022	58	$ 17,755.39
April 2022	245	$ 56,073.38
May 2022	44	$ 13,024.50
June 2022	52	$ 13,574.18
July 2022	319	$ 74,027.61
August 2022	33	$ 6,227.93
September 2022	91	$ 18,331.45
Total	**1,297**	**$ 313,659.24**

Other ProDUR Alert Cost Saving			
Month	**Alert**	**Claims Cancelled**	**Cost Savings**
October 2021	DA	2	$429.98
	DC	7	$1,902.05
	DD	21	$3,557.88
	HD	10	$978.10
	ID	24	$3,087.89
	LR	5	$3,569.95
	MC	2	$101.98
	PG	26	$4,361.17
	TD	13	$3,361.32
November 2021	DD	2	$29.61
	HD	1	$34.99
	ID	17	$6,623.57
	LR	1	$159.49
	MX	1	$36.99
	TD	2	$2,347.54
December-21	DC	1	$65.99
	DD	4	$605.75
	HD	1	$0.01

	ID	14	$2,340.97
	TD	4	$3,193.88
January-22	DD	24	$2,096.18
	HD	22	$2,062.85
	ID	8	$2,139.92
	LD	14	$637.03
	MX	4	$523.30
	TD	25	$3,879.29
February-22	DC	2	$238.40
	DD	3	$686.67
	ID	16	$3,577.96
	TD	2	$1,666.23
March-22	DC	1	$94.99
	DD	44	$3,648.77
	HD	6	$713.88
	ID	19	$2,073.31
	LD	8	$458.64
	LR	11	$1,187.58
	MC	1	$502.91
	TD	10	$1,610.24
April-22	DC	6	$394.86
	DD	30	$7,457.73
	HD	2	$36.17
	ID	34	$5,044.29
	LD	6	$268.56
	MX	2	$46.98
	TD	20	$4,275.85
May-22	DD	17	$2,144.70
	ID	16	$2,375.01
	LR	1	$142.60
	TD	1	$275.55
June-22	DD	6	$130.02
	ID	14	$1,953.66
	TD	3	$1,873.39
July-22	DA	2	$83.91
	DC	2	$4,501.99
	DD	34	$7,157.32
	HD	1	$21.56
	ID	37	$6,427.24
	LR	4	$188.17
	MC	2	$303.00

	MX	3	$86.37
	PG	1	$2,103.91
	TD	13	$3,745.89
August-22	DC	1	$146.99
	DD	16	$2,890.40
	ID	13	$3,641.06
	LR	2	$6.57
	TD	3	$135.83
September-22	DD	22	$5,239.20
	HD	6	$44.70
	ID	19	$2,767.52
	MC	1	$219.99
	MX	2	$89.88
	TD	1	$104.20
Total		**721**	**$130,912.33**
FFY 2022 Totals		**2,018**	**$444,571.57**

Appendix C – RetroDUR Summary

RetroDUR_Report_2021-2022_Q4.pdf

Appendix D – PDL Changes

PDLs from October 2021 - September 2022

Oregon Medicaid Preferred Drug List – October 1, 2021
Oregon Medicaid Preferred Drug List – January 1, 2022
Oregon Medicaid Preferred Drug List – April 1, 2022
Oregon Medicaid Preferred Drug List – July 1, 2022

Appendix E – Cost Avoidance Methodology Details

Cost avoidance is calculated based on the initial claim (index event) and the final disposition of therapy within the drug class for a member. The types of cost avoidance are: deferred, therapeutic duplication, switched, add-on, discontinued, and other. Each cost avoidance type has a distinctive calculation for the duration of cost avoidance and the amount saved, based on the most likely clinical treatment pathway.

Deferred cost avoidance includes claims for which the requested therapy is eventually approved and savings are calculated based on the time from the initial request to the first paid claim.

Therapeutic duplication cost avoidance is calculated when a drug is denied when there are already paid claims for an alternative in the same drug class.

Switch cost avoidance covers situations when a restricted access drug (PA required or non-preferred) is denied, but an alternative within the PDL class is subsequently paid. The difference in cost between the initial drug requested and the actual drug dispensed is the cost avoided.

Add-on therapy is calculated when a drug is denied when there are already paid claims for an alternative that treats the same condition.

There are limitations to the cost avoidance methodology. The method is dependent upon detecting a denied claim. Members new to the Medicaid program or newly marketed medications are examples of situations that make it more difficult to adequately track and model potential savings. However, providers who have learned the FFS Medicaid PDL (or have learned to consult it) will prescribe preferred and unrestricted medications without first generating a denied claim for a drug requiring prior authorization. These types of long-term behavior modifications represent significant cost saving for the FFS program but are difficult to reliably quantify. Another limitation of the methodology occurs at the beginning and end of the reporting periods. Only costs avoided due to an initial denied claim during the reporting period are included. When an index event occurs immediately before the reporting period, there are savings associated with that event which are not summarized in the report. Likewise, when the initial denied claim occurs immediately before the end of the reporting period, the costs avoided after the end of the reporting period are not included. Significant savings go undetected with the methodology in the interest of conservative reporting. The methodology may also potentially inflate savings. For example, savings might be overestimated by assuming a chronic medication would have otherwise continued to be filled throughout the reporting period if not for the intervention.