FFY 2025 MEDICAID FEE-FOR-SERVICE (FFS) DRUG
UTILIZATION REVIEW (DUR) ANNUAL SURVEY

I. ENROLLEE INFORMATION

State Abbreviation: OR

Medicaid Program Information

Identify state person responsible for DUR Annual Report Preparation.

First Name: Brandon

Last Name: Wells

Email Address: Brandon.Wells@oha.oregon.gov

Position Title: Pharmacy Program Manager

1. On a monthly 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?

   93,245 Beneficiaries

2. On a monthly average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s) that provides drug benefit(s)?

   1,150,589 Beneficiaries

II. PROSPECTIVE DUR (ProDUR)

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

- (○) State-Operated
- (●) Contractor
- (○) Other

a. Vendor Name

Gainwell Technologies

b. Who processes the state's National Council for Prescription Drug Programs (NCPDP) transactions?

- (●) POS vendor is the fiscal agent (FA)
- (○) POS vendor is a separate Pharmacy Benefits Manager (PBM)
- (○) Other, please explain.

2. Identify your ProDUR table driven criteria source. This would be initial ratings such as drug to drug interactions, dose limits based on age, etc. Check **all** that apply:

- [✔] First Databank
- [ ] Medi-Span
- [✔] Micromedex
- [ ] Other, please specify _____

3. When the pharmacist receives a 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
- (○) Varies by Alert Type
- (○) No

If *"Yes"* or *"Varies by Alert Type,"* check **all** that apply:

- [ ] Alerts can be overridden ahead of time
- [✔] Alerts can be overridden with standard professional codes
- [ ] Alerts need prior authorization (PA) to be overridden
- [ ] Other, please explain.

4. Does your state receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail?

- (●) Yes
- ( ) No, please explain.

a. If "*Yes,*" How often does your state receive reports?

- [ ] Monthly
- [x] Quarterly
- [ ] Annually
- [x] Ad hoc (on request)
- [ ] Other, please explain.

b. If "*Yes,*" does your state follow up with those providers who routinely override with interventions?

- ( ) Yes

If "*Yes*," by what method does your state follow up?

- [ ] Contact Pharmacy
- [ ] Refer to Program Integrity for Review
- [ ] Other, please explain.

(●) No, please explain.

Oregon FFS relies on the dispensing pharmacist to document and enter the appropriate invention and outcome codes.

5. **Early Refill**

a. At what percent threshold does your state set your system to edit?

i. Non-controlled drugs:

80 %

ii. Schedule II controlled drugs:

80 %

iii. Schedule III through V controlled drugs:

80 %

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

When an early refill message occurs, does your state require a PA?

( ) 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 POS?

(●) Yes
( ) No

c. **For controlled drugs:**

When an early refill message occurs, does your state require a PA?

( ) Yes

(●) No

If *"Yes,"* who obtains authorization?

( ) Pharmacist
( ) Prescriber
( ) Pharmacist or Prescriber

If *"No,"* can the pharmacist override at the POS?

(●) Yes
( ) No

6. 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 (check all that apply):

☑ Lost/stolen RX
☑ Vacation
☐ Overrides are only allowed by a pharmacist through a PA
☑ Other, please explain.

As long as the pharmacist enter a valid Submission Clarification Code and the appropriate intervention and outcome codes, the pharmacist can use whichever ones apply. Oregon FFS do not limit which ones can be used.

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

( ) Yes
(●) No

Does your state plan to implement this edit?

( ) Yes
(●) No

8. Does the state Medicaid program 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

9. Does your system have a diagnosis edit that can be utilized when processing a prescription?

- ( ) Yes, please explain.

- (●) No

10. Does your Medicaid program have a documented process (i.e., PA) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any rebate participating manufacturer covered outpatient drug when medically necessary?

- (●) Yes

Please check **all** that apply:

- [✔] Automatic PA based on diagnosis codes or systematic review
- [✔] Trial and failure of first or second-line therapies to support Preferred Drug List
- [✔] Pharmacist or technician reviews
- [ ] Direct involvement with Pharmacy and/or Medical Director
- [✔] Other, please explain.

Claim would deny with a message informing the pharmacy that a drug requires a prior authorization. Prescriber submits prior authorization request to vendor via phone, fax, mail, or provider web portal. Prior authorization request is reviewed and responded to within 24 hours.

- ( ) No, please explain why not.

a. How does your program provide for the dispensing of at least a 72-hour supply of a covered outpatient drug (COD) in an emergency situation? Please check **all** that apply:

- [ ] Real-time automated process
- [ ] Retrospective PA
- [x] Other process

Please explain.

Pharmacy can call the Oregon Pharmacy Call Center 7 days a week to request

[Full text reads: "Pharmacy can call the Oregon Pharmacy Call Center 7 days a week to request a 96-hour emergency supply for a drug that is needing a prior authorization. Emergency supplies permitted as long as the drug is rebatable and covered."]

11. 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 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 (QL), Early Refill (ER), PA, Therapeutic Duplications (TD), and Age Edits (AE))

Column 4 – Top 10 Drug Names by Amount Paid, 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, 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

NOTE: If an entry is not included in the drop-down box list, please enter response as freeform text in the area provided within the Table.

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 (i.e., Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD) and Age Edits (AE))**	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)**
quetiapine fumarate	Ataractics, Tranquilizers	CLAIM FAILED A PRODUR ALERT	paliperidone palmitate	12.7 %	bupropion HCl	9.3 %
omeprazole	Psychostimulants, Antidepressants	CLAIM DENIED FOR PRODUR REASONS	cariprazine HCl	10.3 %	sertraline HCl	8.4 %
pantoprazole sodium	Antacids	EXACT DUPLICATE	aripiprazole	6.8 %	trazodone HCl	7 %
lorazepam	Diabetic Therapy	DRUG QUANTITY PER DAY LIMIT EXCEEDED	brexpiprazole	5.3 %	fluoxetine HCl	6.4 %
blood-glucose sensor	Anticonvulsants	NDC REQUIRES PA	bupropion HCl	2.8 %	escitalopram oxalate	6.3 %
esketamine HCl	Medical Supplies		lumateperone tosylate	2.8 %	duloxetine HCl	5.3 %
semaglutide	Miscellaneous		esketamine HCl	2.5	lamotrigine	4.9 %
sertraline HCl	Gluco Corticoids		sertraline HCl	1.9 %	buspirone HCl	4.1 %
guanfacine alprazolamHCl	Non-narcotic Analgesics		aripiprazole lauroxil	1.8 %	quetiapine fumarate	3.4 %
alprazolam	All Other Dermatologicals		vortioxetine hydrobromide	1.8 %	aripiprazole	3.2 %

12. Section 1927(g)(A) of the 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 Program
- [x] State Board of Pharmacy
- [ ] Other, please explain.

a. Please explain the steps taken by the state agency to monitor compliance by pharmacies with the prospective DUR counseling requirements contained in federal and state laws and regulations.

Contractually required.

III. RETROSPECTIVE DUR (RetroDUR)

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

- ○ Vendor
- ◉ Academic Institution
- ○ Other Institution

a. Identify, by name, your RetroDUR vendor.

Oregon State University, College of Pharmacy, Drug Use Research & Mana

b. Is the RetroDUR vendor the Medicaid Management Information System (MMIS) fiscal agent?

- ○ Yes
- ◉ No

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

- ◉ Yes
- ○ No

Please explain *"Yes"* or *"No"* response.

DURM evaluates drugs, conducts drug class reviews, and performs drug use and policy evaluations based on sound evidence-based research and processes widely accepted by the medical profession. These evidence summaries and drug use evaluations are presented to the DUR Board/P&T Committee and inform the recommendations for management of the PDL and clinical prior authorization criteria. Recommendations are aimed to encourage safe, effective, and innovative drug policies that promote high value medications for patients served by the Oregon Health Plan (OHP). DURM also publish and distribute educational information to prescribers and pharmacists regarding the committee activities and the drug use review programs.

d. Does your state customize your RetroDUR vendor criteria?

- ◉ Yes
- ○ No
- ○ Ad hoc based on state-specific needs

2. How often does your state perform retrospective practitioner-based education?

- ○ Monthly
- ◉ Bi-monthly
- ○ Quarterly

◯ Other, please specify.

a. How often does your state perform retrospective reviews that involve communication of client specific information to healthcare practitioners (through messaging, fax, or mail)? Check **all** that apply:

- ☐ Monthly
- ☐ Bi-Monthly
- ☐ Quarterly
- ☑ Other, please specify.

Retrospective reviews that involve communication of client specifi

b. What is the preferred mode of communication when performing RetroDUR initiatives? Check **all** that apply:

- ☐ Mailed letters
- ☐ Provider phone calls
- ☑ Near real-time fax
- ☐ Near real-time messaging
- ☐ Other new technologies such as apps or Quick Response (QR) codes
- ☐ Focused workshops, case management, or online training
- ☑ Newsletters or other non-direct provider communications
- ☐ Other, please specify _____

3. **Summary 1 – RetroDUR Educational Outreach**

RetroDUR Educational Outreach Summary should be a year-end report on retrospective screening and educational interventions. The summary should be limited to the most prominent problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed below.

Change Forms:Aripiprazole Rapid Dissolve Tabs to Oral Tabs: Faxes sent-35; Rx changed w/in six months-13; cumulative pharmacy payment reduction (12 months)-$9910Desvenlafaxine Salt Formulations: Faxes sent-301 Rx changed w/in six months-206; cumulative pharmacy payment reduction (12 months)-$228939Expert Consultation Referral: Long Term Antipsychotic Use in Children: high-risk patients identified-3627; prescribers successfully notified-36; change in Rx within 90 days-2; no change w/in 90 days-34; discontinued within 90days-3Non-Adherence: Antipsychotics in people w/schizophrenia: Prescribers successfully notified-226; Patients with claims for the same antipsychotic within the next 90 day-111; Patients with claims for a different antipsychotic within the next 90 day-9High Risk Patient Profile Reviews:Bipolar profiles reviewed-96; Letters sent to providers-57Mental Health profiles reviewed-101; Letters sent to providers-102Opioids profiles reviewed-80; Letters sent to providers-48Polypharmacy profiles reviewed-80; Letters sent to providers-41Safety Net:Antipsychotics for children <=5 years of age: Prescribers successfully notified-65; Patients with paid claims within next 60 days-61; Patients with denied claims within next 60 days-66Safety Net: PA Denials

with no subsequent PA requested or dangerous drug combinations:Combination Opioid-Sedative: Prescribers successfully notified-247; Patients with discontinuation of therapy within next 90 days-89; Patients with new prescription for naloxone within next 90 days-7;Oncology Denials: Prescribers successfully notified-6; Patients with claims for the same drug within the next 90 days-45 Patients with claims for any oncology agent within the next 90 days-5TCAs in Children: Total patients identified-40; Prescribers successfully notified-22; Patients with claims for a TCA w/in the next 90 days-9; Patients with claims for an alternate drug (SSRI, migraine prevention, or diabetic neuropathy) w/in the next 90 days-2

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IV. DUR BOARD ACTIVITY

1. Does your state have an approved Medication Therapy Management (MTM) Program?

   ○ Yes
   ◉ No

2. Does your state have a separate advisory board for your Preferred Drug List (PDL)?

   ○ Yes
   ◉ No

3. **Summary 2 – DUR Board Activities**
   DUR Board Activities Summary should include a brief descriptive report on DUR activities during the fiscal year reported. This summary should:

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

DUR Board meetings held: 6Additions/deletions to DUR Board approved criteria:Added new FDA-approved antineoplastic agents to Table 1 in the Oncology Agents PA criteria.Updated Table 1 in the Orphan Drugs PA criteria to support medically appropriate use new orphan drugs or expanded indications based on FDA-approved labeling.Retired the Pegylated Interferons and Ribavirins PA criteriaImplemented PA criteria for nonpreferred pharmacy claims for immunoglobulin (Ig) to support off label use of Ig for evidence supported diagnosesUpdated the PA criteria for Injectable Multiple Sclerosis (MS) Drugs to add an assessment for the JC virus titer for ocrelizumab in Table 2, to remove the required step therapy in the Natalizumab PA criteria and apply to ublituximabUpdated the Testosterone PA criteria to clarify medically appropriate useImplemented the Budesonide Oral Suspension PA criteriaUpdated the Duchenne Muscular Dystrophy PA criteria to incorporate the expanded indications for delandistrogene moxeparvovec and givinostatImplement the Potassium Competitive Acid Blockers PA for vonoprazan monotherapy and remove reference to Prioritized List from the Proton Pump Inhibitor (PPI) PA criteriaMoved inebilizumab-cdon, ravulizumab-cwvz, satralizumab-mwge, eculizumab, eculizumab-aeeb, eculizumab-aagh, pegcetacoplan, and crovalimab-akkz to the Orphan Drug Class; removed their PDL designation; retired their drug specific PA criteria and apply the Orphan Drugs policyImplemented PA for donanemabUpdated the Alzheimer's Disease Monoclonal Antibodies PA criteriaImplemented PA criteria for Winrevair (sotatercept_csrk) to support use as add_ on treatment in PAHImplemented PA for preferred PDE_5 inhibitors to prevent coverage for treatment of erectile dysfunction in men and auto approve prescriptions for any of the following: diagnosis of PAH; prior claims for other PAH drug classes; identified female gender; or prescriptions written by a pulmonologistUpdated Oral Roflumilast PA criteria_Updated the Targeted Immune Modulators for Severe Asthma and Atopic Dermatitis PA criteria to

include dupilumab use in adults with inadequately controlled COPD on triple inhaler therapyImplemented the Ensifentrine PA criteria to ensure guideline-directed therapy prior to adding ensifentrine to a therapeutic regimenImplemented auto PA to allow continuation of Urea Cycle Disorders therapy for the non_preferred agentsRevised the Bone Metabolism Agents PA criteria to align with recently published guidelines and FDA safety alertsRetired Platelet Inhibitors PA criteria and default to general Preferred Drug List (PDL) _ Non-Preferred Drugs in Select PDL Classes PA criteriaUpdated the SGLT-2 Inhibitor PA criteria to include evidence of benefit for empagliflozin in patients with chronic kidney disease without diabetesUpdated the Rifaximin & Rifamycin PA criteria with the expanded indication for rifaximin in the management of IBS with diarrhea, and auto PA rifamycin when prescribed with lactulose_Added a pathway to coverage for adults with IBS_C or IBS_D to the Drugs for Constipation PA criteriaUpdated the Parkinson's Disease Drugs PA criteria to support medically appropriate use of foscarbidopa/foslevodopa in advanced Parkinson's diseaseImplemented the Cobenfy (xanomeline/trospium chloride) PA criteriaAmended the Skyclarys (omaveloxolone) PA criteria to: require the medication be prescribed by, or in consultation with, a neurologist; add genetic confirmation of Friedreich's ataxia (FDRA); and remove the requirement that patients be ambulatoryImplemented the Vadadustat PA criteria to ensure appropriate and safe use, and retired the Daprodustat PA criteriaRevised the Fezolinetant PA criteria to stipulate duration of hormonal step therapy, added a recommendation for use of an SSRI, SNRI, or gabapentin in addition to hormonal therapy, and added recent FDA guidance for liver function monitoring while taking fezolinetantReviewed an Oncology Drug Policy Evaluation and concluded there were few delays in members accessing therapy and the PA has not been a barrier to access, so recommended continuing to require PA for newer antineoplastic medications due to their high costs and ongoing accelerated approvalsAmended the Weight Management Drugs PA criteria to allow coverage of tirzepatide for patients with obstructive sleep apnea (OSA) and obesityImplemented the Tryvio (aprocitentan) PA criteriaEncouraged implementing cost effective evidence_based step therapy for certain cancer indications supported by clinical guidelinesRetired Clobazam PA criteria based on compendia support for treatment resistant seizures and make at least one formulation of clobazam preferred Revised Pregabalin PA criteria to include medically appropriate use for fibromyalgia for patients with the EPSDT BenefitUpdated the CGRP Antagonist and Antimigraine_ Serotonin Agonist PA criteria with clerical updates and new drug additions Implemented the Butalbital Containing Products PA criteriaImplemented PA criteria for topical anticholinergics and onabotulinumtoxinA to limit use to people with a diagnosis of primary axillary hyperhidrosis, severe symptoms that interfere with daily activities, when prescribed by, or in consultation with, a dermatologist and when symptoms have failed to respond to non_pharmacologic lifestyle management _Recommended onabotulinumtoxinA as a preferred option for treatment of hyperhidrosis based on large treatment effect size and relatively long duration of effectUpdated the Botulinum Toxins PA criteria to incorporate coverage for chronic anal fissures in eligible populationsRecommended adding the Topical Agents for Actinic Keratosis drug class to the PDL and to designate at least one topical formulation of 5-fluorouracil (5-FU) and imiquimod _ indicated for treatment of basal cell carcinoma and genital warts _ as preferred agents, and to maintain diclofenac 3% gel as nonpreferred, and make tirbanibulin 1% ointment and aminolevulinic acid gel nonpreferredRevised the Tesamorelin PA criteria to define medical necessity and clinical appropriateness for patients eligible for coverage under EPSDTRecommended adding a Drugs for Dry Eye drug class to the PDL and make all prescription products for the treatment of dry eye and vernal keratoconjunctivitis nonpreferred based on clinical evidenceImplemented the proposed Targeted Drugs for Dry Eye Disease PA criteria to provide a pathway for coverage for therapies for vernal keratoconjunctivitis for patients with comorbidities which allow for funding of dry eye, or who qualify under EPSDTUpdated the Esketamine PA criteria to clarify documentation required to support diagnosis and permit monotherapy with esketamine in people with treatment-resistant depressionImplemented the Suzetrigine PA criteria for use beyond 48 hours and to limit use to no more than 14 daysAdded a Molluscum Contagiosum drug class to the PDL to include cantharidin topical solution 0.7% (Ycanth) and berdazimer gel 10.3% (Zelsuvmi).Implemented the Molluscum Contagiosum PA criteria for cantharidin and berdazimer to define medical necessity under EPSDTAdded coverage for oral solid dosage forms, powders, and concentrated liquids of nutritional supplements for people with inborn

errors of metabolism and to implement the Nutritional Supplements as Prescribed Drugs for Special Conditions PA criteria to limit coverage to specific nutritional supplements based on current standards of care for those eligible under EPSDTImplemented the Dextromethorphan/Quinidine PA criteria to define medical necessity under EPSDT and maintain Neudexta as nonpreferred on the PDLRecommended making Casgevy (exagamglogene autotemcel) and Lyfgenia (lovotibeglogene autotemcel) preferred on the PDL and to modify the Gene Therapies for Sickle Cell Disease PA criteria to allow Oregon to participate in the Cell and Gene Therapy Access Model for sickle cell disease gene therapies Discontinued the Lovotibeglogene Autotemcel PA criteriaRecommended automatically approving requests for modafinil or armodafinil for members with narcolepsy when prescribed for daily doses at or below 200 mg for modafinil or 250 mg for armodafinil, but continue to require PA for other indications and for higher dosesUpdated the Sleep-Wake Medications PA criteria to approve higher doses of modafinil when lower doses are only partially effectiveMade entecavir tablets preferred on the PDL based on recent guidelines and made lamivudine non-preferred due to viral resistance patternsMade Vykat XR (diazoxide choline) extended-release tablets non-preferred on the PDL and implemented the Diazoxide Choline Extended-Release Tablets PA criteria to ensure appropriate use in patients with hyperphagia due to Prader-Willi syndromeProDUR reports are presented quarterly, and results inform potential changes to PA criteria and RetroDUR initiatives.RetroDUR reviews and Drug Use Evaluations inform changes to PA criteria and ProDUR edits.DUR Board involvement in education (e.g. 11 Oregon State Drug Review Newsletters published):New and Emerging Therapies for Metabolic Dysfunction-Associated Steatotic Liver Disease/Metabolic Dysfunction-Associated Steatohepatitis (MASLD/MASH) in Adults Update on the Biosimilar Landscape in the United States MarketReview of Off-Label Use of Gabapentin and PregabalinOff-label Uses of GLP-1 Receptor Agonists and Dual GLP-1/GIP Receptor AgonistsPharmacologic Management of Vasomotor Menopausal SymptomsThe Mental Health Clinical Advisory GroupPharmacotherapeutic Options for Treating Adolescents with Opioid Use DisorderMedication Safety UpdateNew Therapies for Treatment of Chronic Obstructive Pulmonary DiseaseNew Drugs for the Treatment of Uncomplicated Urinary Tract Infections2025 American College of Cardiology/American Heart Association Joint Committee Clinical Practice Guideline Update

V. PHYSICIAN ADMINISTERED DRUGS (PAD)

1. Has your MMIS been designed to incorporate national drug code (NDC) numbers for covered outpatient physician administered drugs into your DUR criteria for ProDUR?

   ○ Yes
   ◉ No

   If *"No,"* does your state have a plan to include this information in your DUR criteria in the future?

   ○ Yes
   ◉ No

2. Has your MMIS been designed to incorporate national drug code (NDC) numbers for covered outpatient physician administered drugs into your DUR criteria for RetroDUR?

   ◉ Yes
   ○ No

   If *"No,"* does your state have a plan to include this information in your DUR criteria in the future?

   ○ Yes
   ○ No

VI. GENERIC POLICY AND UTILIZATION DATA

1. Summary 3 – Generic Drug Substitution Policies

Generic Drug Substitution Policies should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, PDL policies, educational initiatives, technology or promotional factors, or other state specific factors that affects your generic utilization rate.

By Administrative rule OAR 410-121-0030 (5)(a)&(b) pharmacy providers dispense prescriptions in the generic form unless the practitioner requests otherwise pursuant to OAR 410-121-0155 and/or OAR 410-121-0040. Providers shall obtain prior authorization (PA) for the brand drugs and categories of drugs requiring PA in this rule, using the procedures set forth in OAR 410-121-0060. If the cost of the brand name drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug, then the Division may prefer the brand product over the generic after notifying pharmacies of the policy change. Mental health drugs are carved out of CCO budgets and are reimbursed directly by FFS. Because mental health drug utilization is very strongly skewed toward generics, the overall FFS generic percentage is also skewed more toward generics than the percentages reported by CCOs.

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(s)
- [x] Prior authorization (PA) is required
- [ ] Other, please explain.

Table 2: Generic Drug Utilization Data

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 "*National Drug Code and Drug Category file* [ZIP]," then open the Medicaid Drug Product File 4th Qtr. Excel file).

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

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	92,904	2,853,564	35,844
Total Reimbursement Amount Less Co-Pay	109,805,872	43,072,182	28,403,870

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

Number of Generic Claims: 2,853,564

Total Number of Claims: 2,982,312

Generic Utilization Percentage: 95.68 %

4. Does your Medicaid program have a brand over generic program when the brand product nets a lower cost?

(●) Yes
( ) No

5. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period using the computation instructions in **Table 2: Generic Drug Utilization Data**.

Generic Dollars: $43,072,182

Total Dollars: $181,281,924

Generic Expenditure Percentage: 23.76 %

6. Does your state have any policies related to biosimilars? Please explain.

When a product becomes available that is a biosimilar for one or more drugs that have been reviewed for the PDL, where applicable, the new product will be designated a nonpreferred drug until the P&T Committee reviews the product.

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:

   ( ) Vendor
   (●) Academic Institution
   ( ) Other Institution

   Institution Name

   OSU College of Pharmacy, Drug Use Research & Management Program, and

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

	Cost in Dollars
ProDUR Total Estimated Avoided Costs	601,246.99
RetroDUR Total Estimated Avoided Costs	257,569
Other Cost Avoidance	21,440,658
Grand Total Estimated Avoided Costs	22,299,473.99

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 5, then multiplying this value by 100.

   Estimated Percent Impact: 12.3 %

4. Does your program allow pharmacists to order either prescription or OTC medications through:

- ◯ Standing orders
- ◯ Collaborative practice agreements
- ◉ State Board authorized prescriptive authority
- ◯ Other predetermined protocols, please explain.

What categories of drugs are dispensed through these types of agreements?

Hormonal contraceptive patches and oral contraceptives, Insulin, Drugs u

5. **Summary 4 – Cost Savings/Cost Avoidance Methodology**

Cost Savings/Cost Avoidance Methodology Summary should include program evaluations/cost savings estimates prepared by the state or contractor. Please provide detailed summary below.

ProDUR Methodology: Claims that trigger ProDUR alerts are not always deni

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4. Does your program allow pharmacists to order either prescription or OTC medications through:

- ○ Standing orders
- ○ Collaborative practice agreements
- ◉ State Board authorized prescriptive authority
- ○ Other predetermined protocols, please explain.

What categories of drugs are dispensed through these types of agreements?

Hormonal contraceptive patches and oral contraceptives, Insulin, Drugs used for opioid use disorder (OUD), Cough and cold medications as specified by the Oregon Board of Pharmacy, COVID antiviral drugs, HIV post-exposure and pre-exposure prophylaxis, short-acting opioid antagonists, Travel medications, and Tobacco cessation.

5. **Summary 4 – Cost Savings/Cost Avoidance Methodology**

Cost Savings/Cost Avoidance Methodology Summary should include program evaluations/cost savings estimates prepared by the state or contractor. Please provide detailed summary below.

ProDUR Methodology: Claims that trigger ProDUR alerts are not always denied. The pharmacist will receive a denial for Early Refill (ER) or Pregnancy-Drug Interaction (PG) alerted claims but does not receive a denial when entering a claim that triggers any other informational alerts. Instead, the pharmacist receives an informational alert message that may help them make decisions about dispensing the drug. After receiving a denied ProDUR alert or an informational alert, the pharmacist may choose to override the alert, cancel the claim, resubmit a different claim, or take no action. The cost savings due to claims that were not dispensed because of these alerts is defined as being cancelled and then not being reprocessed again at a later date. RetroDUR and Cost Avoidance Methodology:The DURM group created a cost-avoidance methodology designed to conservatively estimate cost avoidance and avoid common overestimations. 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 for PA required or non-preferred status, all subsequent claims (paid and denied) for the member within the drug class are monitored. 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 themethodology in the interest of conservative reporting. The methodology may also potentially inflate savings. For example, assuming a denied claim for a chronic medication would have continued to be filled throughout the reporting period, or until the member dis-enrolled could overestimate savings resulting from the intervention.Brand over Generic: Select brand name medications are preferred over their generic alternatives when the net cost has been determined to provide substantial Cost Savings to the program.

VIII. FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

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

- (●) Yes
- ( ) No, please explain why not.

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

- [✔] Deny claims
- [✔] Require prior authorization (PA)
- [✔] Refer to Lock-In Program
- [ ] Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
- [ ] Refer to Office of Inspector General (OIG)
- [ ] Other, please explain.

2. Does your state have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?

- (●) Yes
- ( ) No

If *"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

- [x] Multiple pharmacies
- [x] Days' supply of CS
- [ ] Exclusivity of short acting opioids
- [x] Multiple emergency room (ER) visits
- [ ] Prescription drug monitoring program (PDMP) data
- [ ] Other, please explain.

b. Does your state 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 incidences/occurrences
- ○ Other, please explain.

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

0 %

i. Does your state have a documented process in place that identifies possible FWA of controlled drugs by **prescribers**?

(●) Yes

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

- [x] Deny claims written by this prescriber
- [x] Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
- [ ] Refer to the appropriate Medical Board
- [ ] Other, please explain.

( ) No, please explain why not.

j. Does your state have a documented process in place that identifies potential FWA of controlled drugs by **pharmacy providers**?

(●) Yes

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

- [x] Deny claim
- [x] Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
- [ ] Refer to Board of Pharmacy
- [ ] Other, please explain.

○ No, please explain why not.

5. Does your state have a documented process in place that identifies and/or prevents potential FWA of non-controlled drugs by **beneficiaries, prescribers, and pharmacy providers**?

◉ Yes, please explain your program for FWA of non-controlled substances.

Early refill edit.

○ No, please explain why not.

6. Briefly explain the states' objectives and scope of responsibility between DUR and SUR functions as they relate to FWA. Additionally, explain how the state maintains separation between fraud and abuse and educational activities.

DUR objectives are to provide quality of care and needed services for members focused on appropriate drug therapy, compliance with regulatory requirements, and control of costs. FWA objectives are to monitor, detect and prevent fraud, waste, and abuse to protect government resources. The DUR Board is responsible for making recommendations regarding prospective and retrospective initiatives and utilization controls, while FEA activities are separately administered.

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Does your Medicaid program have the ability to query the state's PDMP database?

- ○ Yes, for all data files
- ○ Yes, for selective beneficiary and provider searches
- ◉ No, please explain.

Legislatively prohibited.

If *"Yes,"* please continue.

a. Please check all applicable ways the state accesses the PDMP database.

- ☐ Receive PDMP data
- ☐ Direct access to the database

i. If *"Receive PDMP data,"* please indicate how often. Check all that apply:

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Other _____

ii. If *"Direct access to the database,"* please specify. Check all that apply:

- ☐ Can query by client
- ☐ Can query by prescriber
- ☐ Can query by dispensing entity

b. Please explain how the state applies this information to control FWA of controlled substances.

c. Does your state also have access to contiguous states' PDMP information?

- ◯ Yes
- ◯ No

2. In the state's PDMP system, which of the following beneficiary information is available to prescribers as close to real-time as possible? Check **all** that apply:

- ☑ PDMP drug history
- ☑ The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period
- ☑ The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills
- ☐ Other, please explain.

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

- ◉ 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).

Oregon State law greatly limits payer access to the PDMP, State Medicaid agency (OHA) does not have direct access.

- ◯ No

3. How have you communicated to prescribers who are covered providers that they are required to check the PDMP before prescribing controlled substances to beneficiaries who are covered individuals? Check all that apply:

- ☐ Provider bulletin
- ☐ Program website
- ☐ Provider blast fax
- ☐ DUR letter
- ☐ Public notice
- ☑ Provider manual
- ☑ RetroDUR communication

☑ Other, please explain.

Oregon Administrative Rule 410-120-1260 (13) requires enrolled providers to check the Prescription Drug Monitoring Program (PDMP) as defined in Oregon Revised Statute 431A.866 before prescribing a schedule II-controlled substance pursuant to 42 USC 1396w-3a.

a. Has the state specified protocols for prescribers checking the PDMP?

◉ Yes, please explain.

Provider guide best practices statement encourages clinicians to review the patient's history of controlled substance prescriptions using the PDMP before prescribing when starting, and periodically during therapy for all controlled substances.

○ No

b. Do providers receive protocols for responses to information from the PDMP that is contradictory to information that the practitioner expects to receive (example: when a provider prescribing pain management medication finds medications for opioid use disorder (OUD) during a PDMP check, when client denies opioid use disorder)?

○ Yes
◉ No

c. If a provider is not able to conduct PDMP check, does your state require the prescriber to document a good faith effort, including the reasons why the provider was not able to conduct the check?

◉ Yes
○ No, please explain why not.

If *"Yes,"* does your state require the provider to submit, upon request, documentation to the state?

◉ Yes
○ No, please explain.

4. Please specify below the following information for the 12-month reporting period for this survey.

   a. Does your state or professional board require pharmacists to check the PDMP prior to dispensing a controlled substance to a covered individual?

   ○ Yes
   ◉ No, please explain.

   State law requires pharmacists to register, but nothing requires t

   If *"Yes,"* are there protocols involved for pharmacists in checking the PDMP?

   ○ Yes, please explain.

   ○ No

   b. The percentage of covered providers (as determined pursuant to a process established by the state) who checked the prescription drug history of a beneficiary through a PDMP before prescribing a controlled substance to such an individual:

   17.5 %

   i. How was the above calculation obtained?

   ○ A provider survey
   ○ A provider attestation
   ○ A PDMP vendor report
   ○ Raw PDMP data using the median
   ◉ Other, please explain.

Using raw PDMP data, we report the median ratio of the number of times a covered provider checked the PDMP to the number of controlled substance prescriptions tied to the covered provider. It is not limited to just prescriptions to "covered individuals". Due to system limitations, Oregon cannot report data separately for FFS and each CCO.

c. For sub questions d., e., f., g. and the Tables 3, 4, 5 and 6 below, please specify the type of data utilized in determining the calculations.

- ○ Raw PDMP data
- ○ MMIS claims
- ○ A PDMP vendor report
- ○ Multiple data sources, please explain which source is used for each question below.
- ◉ Other, please explain.

Using raw PDMP data. Counts of 5 or below cannot be disclosed, resulting in blanks.

i. Do these calculations include cash payments?

- ○ Yes
- ◉ No

d. Total morphine milligram equivalents (MME) dispensed in 12-month reporting period:
23,267,70 MME

e. Total MME dispensed per covered individual:
133.32 MME

f. Total MME dispensed per covered individual who received an opioid prescription:
1,240.81 MME

g. Average daily MME dispensed per opioid prescription:
35.6 MME

h. Please complete Tables 3, 4, 5 and 6 below. Specify the controlled substances prescribed based on prescriptions dispensed (by generic ingredient(s)) and within each population during this 12-month FFY reporting period.

Table 3: Opioid Controlled Substances by Population

NOTE: If an entry is not included in the drop-down list in Column 4, please enter a free form response in the text box.

Population	Column 1 Total Number of Beneficiaries Within Each Age Group	Column 2 Total Number of Unique Beneficiaries Within Each Age Group Receiving an Opioid Controlled Substance in the 12-Month Reporting Period	Column 3 Percentage of Unique Beneficiaries Within Each Age Group Receiving an Opioid Controlled Substance in the 12-Month Reporting Period	Column 4 Top 3 Opioid Controlled Substances Received Within Each Age Group (Generic Ingredient) in the 12-Month Reporting Period	Column 5 Number of Unique Beneficiaries Within Each Age Group Receiving the Opioid Controlled Substance (Specified in Column 4) in the 12-Month Reporting Period	Column 6 Percentage of Unique Beneficiaries Within Each Age Group Receiving the Top 3 Opioid Controlled Substances (Specified in Column 4) in the 12-Month Reporting Period
0-18 yrs.	59,087	2,028	3.43 %	hydrocodone/acetaminophen	969	1.64 %
				oxycodone	828	1.4 %
				buprenorphine/naloxone	20	0.03 %
19-29 yrs.	44,373	4,777	10.77 %	oxycodone	1,908	4.3 %
				hydrocodone/acetaminophen	2,106	4.75 %
				buprenorphine/naloxone	159	0.36 %
30-39 yrs.	31,285	4,956	15.84 %	oxycodone	1,934	6.18 %
				buprenorphine/naloxone	475	1.52 %
				hydrocodone/acetaminophen	1,814	5.8 %
40-49 yrs.	19,703	3,875	19.67 %	hydrocodone/acetaminophen	1,554	7.89 %
				oxycodone	1,462	7.42 %
				buprenorphine/naloxone	337	1.71 %
50-59 yrs.	12,668	2,738	21.61 %	hydrocodone/acetaminophen	1,184	9.35 %
				oxycodone	1,064	8.4 %
				buprenorphine/naloxone	141	1.11 %
60-69 yrs.	7,212	1,754	24.32 %	hydrocodone/acetaminophen	744	10.32 %
				oxycodone	705	9.78 %
				tramadol	240	3.33 %
70-79 yrs.	150	30	20 %	oxycodone	18	12 %
				buprenorphine/naloxone	1	0.67 %
				morphine	1	0.67 %
80+ yrs.	50	10	20 %	morphine	1	2 %
				oxycodone	1	2 %
				hydrocodone/acetaminophen	1	2 %
Individuals with Disabilities Utilizing State Eligibility Categories	4,887	614	12.56 %	oxycodone	267	5.46 %
				hydrocodone/acetaminophen	240	4.91 %
				buprenorphine/naloxone	40	0.82 %

Table 4: Top Sedative/Benzodiazepines Controlled Substances by Population

When listing the controlled substances in different drug categories, for the purpose of Table 4 below, please consider long and short acting benzodiazepines to be in the same category.

NOTE: If an entry is not included in the drop-down list in Column 4, please enter a free form response in the text box.

Population	Column 1 Total Number of Beneficiaries Within Each Age Group	Column 2 Total Number of Unique Beneficiaries Within Each Age Group Receiving a Sedative/Benzodiazepine in the 12 Month Reporting Period	Column 3 Percentage of Unique Beneficiaries Within Each Age Group Receiving a Sedative/Benzodiazepine in the 12 Month Reporting Period	Column 4 Top 3 Sedative/Benzodiazepine Received Within Each Age Group (Generic Ingredient) in the 12 Month Reporting Period	Column 5 Number of Unique Beneficiaries Within Each Age Group Receiving the Sedative/Benzodiazepine (Specified in Column 4) in the 12 Month Reporting Period	Column 6 Percentage of Unique Beneficiaries Within Each Age Group Receiving the Top 3 Sedative/Benzodiazepine (Specified in Column 4) in the 12 Month Reporting Period
0-18 yrs.	59,087	1,148	1.94 %	clonazepam	161	0.27 %
				diazepam	300	0.51 %
				lorazepam	326	0.55 %
19-29 yrs.	44,373	1,937	4.37 %	lorazepam	646	1.46 %
				clonazepam	294	0.66 %
				alprazolam	320	0.72 %
30-39 yrs.	31,285	2,266	7.24 %	clonazepam	357	1.14 %
				lorazepam	757	2.42 %
				alprazolam	553	1.77 %
40-49 yrs.	19,703	1,867	9.48 %	alprazolam	477	2.42 %
				lorazepam	593	3.01 %
				clonazepam	284	1.44 %
50-59 yrs.	12,668	1,172	9.25 %	clonazepam	175	1.38 %
				lorazepam	362	2.86 %
				zolpidem	190	1.5 %
60-69 yrs.	7,212	649	9 %	lorazepam	224	3.11 %
				zolpidem	119	1.65 %
				alprazolam	128	1.77 %
70-79 yrs.	150	1	0.67 %	lorazepam	1	0.67 %
				diazepam	1	0.67 %
				N/A	0	0 %
80+ yrs.	50	6	12 %	lorazepam	6	12 %
				N/A	0	0 %
				N/A	0	0 %
Individuals with Disabilities Utilizing State Eligibility Categories	4,887	718	14.69 %	N/A	0	0 %
				N/A	0	0 %
				N/A	0	0 %

Table 5: Top Stimulant/ADHD Controlled Substances by Population

When listing the controlled substances in different drug categories, please consider long and short acting ADHD medications to be in the same category.

NOTE: If an entry is not included in the drop-down list in Column 4, please enter a free form response in the text box.

Population	Column 1 Total Number of Beneficiaries Within Each Age Group	Column 2 Total Number of Unique Beneficiaries Within Each Age Group Receiving a Stimulant/ADHD Controlled Substance in the 12 Month Reporting Period	Column 3 Percentage of Unique Beneficiaries Within Each Age Group Receiving a Stimulant/ADHD Controlled Substance in the 12 Month Reporting Period	Column 4 Top 3 Stimulant/ADHD Controlled Substances Received Within Each Age Group (Generic Ingredient) in the 12 Month Reporting Period	Column 5 Number of Unique Beneficiaries Within Each Age Group Receiving the Stimulant/ADHD Controlled Substance (Specified in Column 4) in the 12 Month Reporting Period	Column 6 Percentage of Unique Beneficiaries Within Each Age Group Receiving the Top 3 Stimulant/ADHD Controlled Substance (Specified in Column 4) in the 12 Month Reporting Period
0-18 yrs.	59,087	4,534	7.67 %	methylphenidate	2,473	4.19 %
				amphetamine	1,228	2.08 %
				lisdexamfetamine	568	0.96 %
19-29 yrs.	44,373	3,188	7.18 %	amphetamine	1,123	2.53 %
				dextroamphetamine/amphetamine	1,015	2.29 %
				methylphenidate	762	1.72 %
30-39 yrs.	31,285	3,585	11.46 %	dextroamphetamine/amphetamine	1,387	4.43 %
				amphetamine	1,232	3.94 %
				methylphenidate	602	1.92 %
40-49 yrs.	19,703	1,914	9.71 %	dextroamphetamine/amphetamine	713	3.62 %
				amphetamine	538	2.73 %
				methylphenidate	318	1.61 %
50-59 yrs.	12,668	802	6.33 %	dextroamphetamine/amphetamine	240	1.89 %
				amphetamine	179	1.41 %
				phentermine	252	1.99 %
60-69 yrs.	7,212	213	2.95 %	dextroamphetamine/amphetamine	53	0.73 %
				amphetamine	40	0.55 %
				phentermine	79	1.1 %
70-79 yrs.	150	1	0.67 %	dextroamphetamine/amphetamine	1	0.67 %
				amphetamine	1	0.67 %
				N/A	0	0 %
80+ yrs.	50	1	2 %	N/A	0	0 %
				N/A	0	0 %
				N/A	0	0 %
Individuals with Disabilities Utilizing State Eligibility Categories	4,887	711	14.55 %	methylphenidate	334	6.83 %
				amphetamine	166	3.4 %
				lisdexamfetamine	131	2.68 %

Table 6: Covered Individuals on 2 or more Controlled Substances in Different Drug Categories

When listing the controlled substances in different drug categories, for the purpose of Table 6 below, please consider long and short acting opioids to be in the same category. Please follow this approach for long and short acting ADHD medications and benzodiazepines in this table as well.

Population	Column 1 Total Number of Beneficiaries within Each Age Group	Column 2 Number of Unique Beneficiaries in Each Age Group Receiving 2 or more Controlled Substances in Different Drug Categories in the 12-Month Reporting Period	Column 3 Percentage of Age Group Receiving 2 or More Controlled Substances in the 12 Month Reporting Period	Column 4 Number of Unique Beneficiaries in Each Age Group Receiving 3 or more Controlled Substances in Different Drug Categories in the 12-Month Reporting Period	Column 5 Percentage of Age Group Receiving 3 or more Controlled Substances in the 12-Month Reporting Period
0-18 yrs.	59,087	535	0.91 %	29	0.05 %
19-29 yrs.	44,373	1,143	2.58 %	90	0.2 %
30-39 yrs.	31,285	1,646	5.26 %	221	0.71 %
40-49 yrs.	19,703	1,348	6.84 %	172	0.87 %
50-59 yrs.	12,668	768	6.06 %	99	0.78 %
60-69 yrs.	7,212	401	5.56 %	29	0.4 %
70-79 yrs.	150	1	0.67 %	1	0.67 %
80+ yrs.	50	1	2 %	1	2 %
Individuals with Disabilities Utilizing State Eligibility Categories	4,887	288	5.89 %	24	0.49 %

i. If there is additional information you want to provide about the calculations and/or the Tables above for the 12-month reporting period, please explain below or **specify N/A if not applicable.**

Oregon PDMP data with count 5 or less cannot be disclosed. Oregon's state Medicaid agency (OHA) directed CCOs to use _1_ as the default response whenever a number is smaller than the allowed reporting level.

j. Has your state exempted certain individuals, (see the definition of Covered Individuals under section 1944(h)(2) of the Act, as added by Section 5042 of the SUPPORT Act), from the associated reporting requirements? Check all that apply:

- [x] Individuals receiving hospice
- [x] Individuals receiving palliative care
- [x] Individuals receiving cancer treatments
- [x] Residents of long-term care facilities or other facility specified in section 1944(g)(2)(B)
- [ ] Babies with neonatal abstinence syndrome (also called NAS)
- [x] Other population 1, please explain individuals with sickle cell dise
- [ ] Other population 2, please explain _____
- [ ] Other population 3, please explain _____

i. If there is any additional information you would like to provide about populations that were included or excluded from the PDMP data, please explain below or respond N/A if not applicable.

N/A

5. Have you had any changes to your state's PDMP during this reporting period that have improved the Medicaid program's ability to access PDMP data?

- ( ) Yes, please explain.
- (•) No

6. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?

- ○ Yes
- ◉ No

If *"Yes,"* please summarize the breach, the number of individuals impacted, a description of the steps the state has taken to address each such breach, and if law enforcement or the affected individuals were notified of the breach.

C. OPIOIDS

1. Does your state currently have a POS edit in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients?

   - (●) Yes, for **all** opioids
   - ( ) Yes, for some opioids
   - ( ) No, please explain why not.

   If the answer to question 1 is *"Yes, for all opioids"* or *"Yes, for some opioids,"* please continue. If the answer to question 1 is "*No*," please skip to 1b.

   a. What is the maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?

      7 # of days

   b. Does your state have POS edits in place to limit days' supply of subsequent opioid prescriptions? If yes, please indicate your days' supply limit.

      - ( ) 24-day supply
      - ( ) 30-day supply
      - ( ) 34-day supply
      - ( ) 90-day supply
      - (●) Other 7
      - ( ) No, please explain.

2. Does your state have POS edits in place to limit the quantity dispensed of opioids?

   - (●) Yes
   - ( ) No, please explain why not.

If "*Yes,*" please continue.

a. Does your state have POS edits in place to limit the quantity dispensed of short- acting (SA) opioids?

- ○ Yes
- ○ No, please explain.
- ◉ Other, please explain.

POS edit to limit days' supply. Quantity varies depending on the agent

b. Does your state currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?

- ○ Yes
- ○ No, please explain.
- ◉ Other, please explain.

All LAOs require PA to support dose optimization, and daily doses are limited to a maximum 90 MME and are subject to frequency limits per FDA-approved labeling detailed in Table 2 of PA criteria: https://www.orpdl.org/durm/PA_Docs/opioids_long_acting.pdf

3. Does your state 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] MME daily dose program
- [x] Step therapy or clinical criteria
- [ ] Requirement that patient has a pain management contract or Patient-Provider agreement
- [ ] Requirement that prescriber has an opioid treatment plan for patients
- [x] Require documentation of urine drug screening results
- [x] Require diagnosis
- [x] Require PDMP checks
- [ ] Workgroups to address opioids
- [ ] Other, please specify.

Please provide details on these opioid prescribing controls in place.

Claim audits to identify diagnosis of concern, such as OUD, or contraindicated concomitant therapy. Prior authorization criteria require attestation that there is documented sustained improvement in pain and function and routine monitoring for opioid misuse. Encourage patients be referred for alternative non-pharmacologic modalities of pain treatment (e.g. physical therapy, supervised exercise, spinal manipulation, yoga, or acupuncture). Ensure member has been prescribed or has access to naloxone and that the prescriber has a pain agreement on file.

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.

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4. Does your state have POS edits to monitor duplicate therapy of opioid prescriptions? This excludes regimens that include a single extended-release product and a breakthrough short acting agent.

- (●) Yes
- ( ) No, please explain why not.

5. Does your state have POS edits to monitor early refills of opioid prescriptions dispensed?

- ( ) Yes, POS edits
- (●) Yes, both POS edits and automated retrospective claims review process
- ( ) No, please explain why not.

6. Does your state have comprehensive automated retrospective claims review to monitor opioid prescriptions exceeding these state limitations (early refills, duplicate fills, quantity limits and days' supply)?

- (●) Yes, please explain in detail scope, nature, and frequency of these retrospective reviews.

RetroDUR Program for High-Risk Opioid Patients: We conduct quarterly manual utilization review for FFS patients who are determined to be highest risk. This program applies to non-excluded FFS patients with a paid or denied opioid claim in the past quarter. Patients are automatically included in the program and are prioritized based on the number of inclusion criteria met (see list below). Those meeting the greatest number of inclusion criteria are reviewed manually each quarter.Prescription and at least one of the following criteria: 90 Morphine Milligram Equivalents (MMEs) cumulative daily dose Concurrent paid claims for short- and long-acting opioids Concurrent paid claims for > 2 unique opioids Multiple paid claims for early opioid fills 3 unique denied claims for opioid prescriptions Patients are prioritized based on the number of inclusion criteria met. Higher priority patients meet more inclusion criteria. Individual patient profiles are reviewed, and the prescriber is lettered with a clinical recommendation.Patients excluded from the report: Patients with a malignant cancer diagnosis or claim for palliative care. Patients with a diagnosis of sickle cell disease in the past year Patients with currently active TPL or Medicare coverage Patients previously reviewed with this initiative in the last 6 months.

◯ No, please explain why not.

7. Does your state currently have automated retrospective claims review to monitor opioids and benzodiazepines being used concurrently?

◯ Yes, automated retrospective claims review

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◉ Yes, both POS edits and automated retrospective claims review

Please explain above response and detail the scope and nature of these reviews and edits. Additionally, please explain any potential titration processes utilized for those patients chronically on benzodiazepines and how the state justifies pain medications, i.e., Oxycodone/APAP, for breakthrough pain without jeopardizing patient care (i.e., quantity limits/practitioner education titration programs).

Several programs monitor concurrent opioids and benzodiazepines. First, prior authorization is required for chronic concurrent therapy. Whenever a benzodiazepine or opioid is denied for prior authorization, a manual review is performed to assess for concurrent use. All long-acting opioids require prior authorization, short-acting opioids require prior authorization when exceeding quantity (90 MME/day) or days' supply limits of 7 days, and benzodiazepines require prior authorization when exceeding 30 days' supply every 120 days. Second, 2 retrospective review programs assess concurrent benzodiazepine and opioid use. In the first RetroDUR program, patients are included based on the following criteria: Patients currently enrolled in fee-for-service [FFS] Medicaid AND Patients prescribed both an opioid and another sedating medication (as defined above) within the past 120 days AND meeting at least one of the following characteristics:1) Patients with prescriptions for opioids and sedatives which overlap by at least 7 days written by more than one provider OR2) Patients with prescriptions for opioids and sedatives from 3 or more unique providers in the past 120 days OR3) Members with a history of sedative poisoning or adverse events within the past 2 yearsPatients are excluded if they meet any of the following criteria:1) Patients not currently enrolled in Medicaid2) Patients who have been had a letter sent within the past 3 months3) Providers who have been messaged for the same patient within the past 12 monthsIn this program, patients are identified weekly and the prescriber of the most recent sedative or opioid will receive the letter.A second RetroDUR Program for High-Risk Opioid Patients (described elsewhere in the report) also identifies patients prescribed concurrent opioids and benzodiazepines for quarterly review.

- ◯ No, please explain why not.

Does your state currently have automated retrospective claims review to monitor opioids and sedatives being used concurrently?

- ◯ Yes, automated retrospective claims review
- ◉ Yes, both POS edits and automated retrospective claims review
- ◯ No, please explain why not.

Does your state currently have automated retrospective claims review to monitor opioids and antipsychotics being used concurrently?

- ◉ Yes, automated retrospective claims review
- ◯ Yes, both POS edits and automated retrospective claims review
- ◯ No, please explain why not.

10. Does your state have POS safety edits or perform automated retrospective claims review and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?

- (●) Yes
- ( ) No, please explain why not.

If *"Yes,"* please check **all** that apply:

- [x] POS edits
- [x] Automated retrospective claims review
- [ ] Provider education

If "*Automated retrospective claims review"* and/or *"Provider education*," please indicate how often.

- ( ) Monthly
- ( ) Quarterly
- ( ) Semi-Annually
- ( ) Annually
- (●) Ad hoc
- ( ) Other, please specify.

If *"No,"* does your state plan on implementing POS edits, automated retrospective claims review and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?

- ( ) Yes, when does your state plan on implementing?

○ No, please explain why not.

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

◉ Yes
○ No

If *"Yes,"* please check **all** that apply:

☑ Your state Medicaid program refers prescribers to the Center for Disease Control (CDC) 2022 Clinical Practice Guideline for Prescribing Opioids for Pain.

☐ Other guidelines, please identify.

If *"No,"* please explain why no guidelines are offered.

12. Does your state 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.

Abuse deterrent opioid medications are available and authorized when

○ No, please explain.

13. Have there been state specific events (unplanned outages, natural disasters, public health emergencies, etc.) that have had ramifications on edits, reviews or prescribing for this reporting period?

- ○ Yes, please explain.
- ◉ No

D. 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?

- ( ) Less than 50 MME, please specify: _____
- ( ) 50 MME
- ( ) 70 MME
- ( ) 80 MME
- (●) 90 MME
- ( ) 100 MME
- ( ) 120 MME
- ( ) 200 MME
- ( ) Greater than 200 MME, please specify: _____
- ( ) Other, please specify:_____
- ( ) More than 1 MME accessed in state

b. Please explain nature and scope of dose limit (i.e., Who does the edit apply to? Does it apply to new users/chronic users? Does the limit apply to **all** opioids? Are you in the process of tapering patients to achieve this limit?).

Applies to all new opioid PA requests and 7-day supplies of SAOs. Grandfathered patients on doses exceeding 90 MME are asked to taper or explain why that is not possible and to provide documentation that the member is benefitting from the therapy - as well as meet all other PA criteria (UDS, PDMP, etc.)

If *"No,"* please explain why not.

2. Does your state have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?

- (●) Yes
- ( ) No, please explain why not.

_____

If "Yes," does your state require PA if the MME limit is exceeded?

- (●) Yes
- ( ) No

3. Does your state have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed?

- (●) Yes
- ( ) No, please explain why not.

4. Do you provide information to your prescribers on how to calculate the MME 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:

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

☑ Other, please explain.

Table of MME for individual agents is included on PA criteria:https://www.orpdl.org/durm/PA_Docs/opioids_long-acting.pdfhttps://www.orpdl.org/durm/PA_Docs/opioids_short-acting.pdf

E. OPIOID USE DISORDER (OUD) TREATMENT

1. Does your state have utilization controls (i.e., PDL, prior authorization (PA), quantity limit (QL)) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?

(●) Yes, please explain.

The FFS program has no restrictions on MAT drugs for OUD with the exception of a quantity limit for transmucosal buprenorphine products which require PA when they exceed an average daily dose of 32mg to prevent use for off-label indications: https://www.orpdl.org/durm/PA_Docs/buprenorphine.pdf

( ) No, please explain.

2. Does your Medicaid program 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.

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

- (●) No limit
- ( ) 3 months or less
- ( ) 6 months
- ( ) 12 months
- ( ) 24 months
- ( ) Other, please explain.

4. Does your state 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?

- ( ) No limit
- ( ) 6 months
- ( ) 12 months
- ( ) Other, please explain.

5. Does your state have at least one buprenorphine/naloxone combination product available without PA?

- (●) Yes
- ( ) No

6. Does your state currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?

- (●) Yes
- ( ) No, please explain why not.

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

- ( ) Yes
- (●) No

7. Is there at least one formulation of naltrexone for OUD available without PA?

- (●) Yes
- ( ) No

8. Does your state have at least one opioid reversal agent available without PA?

- (●) Yes
- ( ) No

9. Does your state monitor and manage appropriate use of opioid reversal agents to persons at risk of overdose?

- (●) Yes
- ( ) No, please explain why not.

10. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid program 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 program under protocol
- ◉ Yes, prescribed independently
- ◯ No

F. OUTPATIENT TREATMENT PROGRAMS (OTP)

1. Does your state cover OTPs that provide Behavioral Health (BH) and MAT services?

- (●) Yes
- ( ) No, please explain why not.

If "*Yes,*" is a referral needed for OUD treatment through OTPs?

- ( ) Yes
- (●) No

Please explain.

No referral required, but providers have to enroll in State Medicaid program, and if applicable, the Coordinated Care Organization (Oregon's MCO).

2. Does your state Medicaid program cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?

- (●) Yes
- ( ) No, please explain.

3. Does your state Medicaid program cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?

- (●) Yes
- ( ) No, please explain.

G. PSYCHOTROPIC MEDICATION

ANTIPSYCHOTICS

1. Does your state have a documented program in place to manage and monitor the appropriate use of antipsychotic drugs in children?

- (●) Yes
- ( ) No

If *"Yes,"* please continue.

a. Does your state manage and monitor:

- ( ) Only children in foster care under 18 years old
- ( ) **All** children including foster care under 18 years old
- (●) Other, please explain.

We monitor all foster care children yearly if prescribed an antipsychotic. For non-foster care children, higher risk children are identified for intervention based on a variety of prescribing characteristics. Specifically, in non-foster care, we're retrospectively monitoring use in children less than 10 years of age prescribed long-term antipsychotics (>90 days) and we select the highest risk ones for intervention. Anyone who isn't in foster care and is over 10 years old isn't monitored. Prospectively we monitor all antipsychotic use in children 2 years of age or younger and antipsychotic use beyond 30 days in children 3-5 years of age.

b. Does your state have edits in place to monitor (check **all** that apply):

- [✔] Child's age
- [ ] Dosage
- [✔] Indication
- [✔] Polypharmacy
- [✔] Other, please explain.

Duration of therapy, metabolic monitoring, and prescriber specialty.

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

For recipients not in foster care, periodic claims reviews for specialist consultation when concerning treatment is identified (e.g. antipsychotic use beyond 30 days in children 3-5 years of age; all antipsychotic use in children 2 years of age or younger; long term antipsychotic use in patients

If *"No,"* please continue.

d. Does your state plan on implementing an antipsychotic monitoring program in the future?

- ○ Yes, please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children.
- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

2. Does your state have a documented program in place to manage and monitor the appropriate use of antipsychotic drugs in individuals over the age of 18 receiving home and community-based services (as defined in section 9817(a)(2)(B) of Public Law 117–2)?

- ◉ Yes
- ○ No

If *"Yes,"* please continue.

a. Does your state have edits in place to monitor (check **all** that apply):

- ☑ Dosage
- ☐ Indication
- ☐ Polypharmacy
- ☑ Other, please explain.

Low doses of quetiapine require prior authorization. No other edits are employed, but our high-risk profile review program is designed to identify high risk populations and concerning therapy.

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

Retrospective claims review to identify members: on dual [or more] antipsychotic therapy; long-term use (>90 days) of 6 or more mental health medications; possible contraindications to therapy for antipsychotics and stimulants, such as elderly patients with dementia-related psychosis and stimulant abuse; or taking medications to treat Alzheimer's disease as well as antipsychotics. Member's profiles are reviewed, and faxes are sent to select prescribers notifying them of potential issues and offer recommendations to help ensure the member's therapy is safe and effective.

If *"No,"* please continue.

c. Does your state plan on implementing an antipsychotic monitoring program in the future?

◯ Yes, please specify when you plan on implementing a program.

◯ No, please explain why you will not be implementing a program.

3. Does your state have a documented program in place to manage and monitor the appropriate use of antipsychotic drugs in individuals over the age of 18 residing in institutional care settings (including nursing facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases, inpatient psychiatric hospitals, and other such institutional care settings)?

◉ Yes
◯ No

If *"Yes,"* please continue.

a. Does your state monitor (check **all** that apply):

☑ Individuals over the age of 18 residing in nursing facilities
☑ Individuals over the age of 18 residing in intermediate care facilities for individuals with intellectual disabilities
☐ Individuals over the age of 18 residing in institutions for mental diseases
☐ Individuals over the age of 18 residing in patient psychiatric hospitals
☑ Individuals over the age of 18 residing in other such institutional care settings. Please explain.

We don't receive claims data for everyone who is in an institutional care setting. Members are included in the high-risk profile reviews and if and when they have pharmacy claims paid by Medicaid.

If your state does not monitor all of the above, please explain why not.

Individuals in inpatient institutions and psychiatric hospitals do not routinely bill individual pharmacy claims to Medicaid. Instead, they are paid at a bundled daily rate for all medications dispensed during the visit and we do not have any data to identify the individual drugs that are dispensed to the patient.

b. Does your state have edits in place to monitor (check **all** that apply):

- [ ] Dosage
- [ ] Indication
- [ ] Polypharmacy
- [x] Other, please explain.

Monitoring is done retrospectively with periodic claims review and provider notification when concerning treatment is identified. Patients residing in institutional settings are included in the program if they have individual claims that are billed to Medicaid. Examples of concerning treatment may include people prescribed more than one antipsychotic therapy, patients prescribed 6 or more mental health medications, patients with Alzheimer's dementia who are prescribed an antipsychotic, and medications with opposing effects (e.g. antipsychotics and stimulants).

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

While we don't know if a member is in an institutional care setting, they are included in the high-risk profile reviews if and when they have pharmacy claims paid by Medicaid. For other members in facilities, Oregon Administrative Rules (OAR) 411-054-0055 outlines facility requirements for safe use and administration of medications dispensed in a facility. These requirements include, but are not limited to, comprehensive medication review by a pharmacist or registered nurse at least every 90 days, and guidance for appropriate psychotropic medication use including required documentation for non-pharmacological interventions, staff training requirements, responsibilities for care coordination and provider oversight, and circumstances for appropriate p.r.n. use of psychotropics.Excerpt from OAR pertaining to psychotropic medication use is below:(6) PSYCHOTROPIC MEDICATION. Psychotropic medications may be used only pursuant to a prescription that specifies the circumstances, dosage and duration of use.(a) Facility administered psychotropic medications may be used only when required to treat a resident's medical symptoms or to maximize a resident's functioning.(b) The facility must not request psychotropic medication to treat a resident's behavioral symptoms without a consultation from a physician, nurse practitioner, registered nurse, or mental health professional. This does not apply when a resident is enrolled in a hospice program as defined in OAR 333-035-0050.(c) Prior to requesting a psychotropic medication, the facility must demonstrate through the evaluation and service planning process that non-pharmacological interventions have been attempted.(d) Prior to administering any psychotropic medications to treat a resident's behavior, all direct care staff administering medications for the resident must know:(A) The specific reasons for the use of the psychotropic medication for that resident.(B) The common side effects of the medications.(C) When to contact a health professional regarding side effects.(e) When a psychotropic medication is ordered by a health care practitioner other than the resident's primary care provider, the facility is responsible for notifying the resident's primary care provider of that medication order within 72 hours of when the facility was notified of the order. This includes weekends and holidays. Notification may be either by telephone or electronic submission and should be documented by

the facility.(f) Medications that are administered p.r.n. that are given to treat a resident's behavior must have written, resident-specific parameters.(A) These p.r.n. medications may be used only after documented; non-pharmacological interventions have been tried with ineffective results.(B) All direct care staff must have knowledge of non-pharmacological interventions.(g) Psychotropic medications must not be given to discipline a resident, or for the convenience of the facility.

If *"No,"* please continue.

d. Does your state plan on implementing an antipsychotic monitoring program in the future?

◯ Yes, please specify when you plan on implementing a program.

◯ No, please explain why you will not be implementing a program.

STIMULANTS

4. Does your state have a documented program in place to manage and monitor the appropriate use of stimulant drugs in children?

- (●) Yes
- ( ) No

a. Does your state manage and monitor:

- ( ) **Only children in foster care under 18 years old**
- (●) **All children including foster care under 18 years old**
- ( ) **Other**

b. Does your state have edits in place to monitor (check **all** that apply):

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

Please explain.

Indication is reviewed when the medication stops for PA and dose and age limits are supported by FDA approved labeling and compendia, or being prescribed by, or in consultation with a psychiatrist.

Please specify age limit. (i.e. 18 years means the edit applies for children under 18.)

6 years

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

Cover ADHD medications only for diagnoses funded by the OHP and medications consistent with current best practices. Promote care by a psychiatrist for patients requiring therapy outside of best-practice guidelines. Regimens prescribed outside of standard doses and age range and non-standard polypharmacy must be prescribed by or in consultation with a relevant specialist (e.g., psychiatrist, developmental pediatrician, psychiatric nurse practitioner, sleep specialist, pulmonologist, or neurologist).

If *"No,"* please continue.

d. Does your state plan on implementing a stimulant monitoring program in the future?

◯ Yes, please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.

◯ No, please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

ANTIDEPRESSANTS

5. Does your state have a documented program in place to manage and monitor the appropriate use of antidepressant drugs in children?

◉ Yes
◯ No

If *"Yes,"* please continue.

a. Does your state manage and monitor:

◉ Only children in foster care under 18 years old
◯ **All** children including foster care under 18 years old
◯ Other, please explain.

b. Does your state have edits in place to monitor (check **all** that apply):

☑ Child's age
☑ Dosage
☐ Indication
☐ Polypharmacy
☐ Other, please explain.

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

Require PA for tricyclic antidepressants in children younger than the FDA approved minimum age. Ensure safe and appropriate use of tricyclic antidepressants in children less than 12 years of age and discourage off label use not supported by compendia: https://www.orpdl.org/durm/PA_Docs/TCAs.pdf

If *"No,"* please continue.

d. Does your state plan on implementing an antidepressant monitoring program in the future?

◯ Yes, please specify when you plan on implementing a program to monitor the appropriate use of antidepressant drugs in children.

◯ No, please explain why you will not be implementing a program to monitor the appropriate use of antidepressant drugs in children.

MOOD STABILIZERS

6. Does your state have a documented program in place to manage and monitor the appropriate use of mood stabilizing drugs in children?

◉ Yes
◯ No

If *"Yes,"* please continue.

a. Does your state manage and monitor:

- ○ Only children in foster care under 18 years old
- ◉ **All** children including foster care under 18 years old
- ○ Other, please explain.

b. Does your state have edits in place to monitor (check **all** that apply):

- ☐ Child's age
- ☐ Dosage
- ☐ Indication
- ☐ Polypharmacy
- ☑ Other, please explain.

Children prescribed more than 4 mental health drugs - which includes mood stabilizers - are included in our high-risk profile reviews.

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

We review profiles of anyone less than 18 years of age with prescriptions for 4 or more mental health drugs with coverage of each drug for at least 60 days in hte past 90 days. Faxes are then sent to prescribers notifying them of the potential issue and offering recommendations to help ensure the member's therapy is safe and appropriate.

If *"No,"* please continue.

d. Does your state plan on implementing a mood stabilizer monitoring program in the future?

- ○ Yes, please specify when you plan on implementing a program to monitor the appropriate use of mood stabilizing drugs in children.

- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of a mood stabilizing drugs in children.

ANTIANXIETY/SEDATIVES

7. Does your state have a documented program in place to manage and monitor the appropriate use of antianxiety/sedative drugs in children?

- (●) Yes
- ( ) No

If *"Yes,"* please continue.

a. Does your state manage and monitor:

- ( ) Only children in foster care under 18 years old
- (●) **All** children including foster care under 18 years old
- ( ) Other, please explain.

b. Does your state have edits in place to monitor (check **all** that apply):

- [✔] Child's age
- [✔] Dosage
- [✔] Indication
- [ ] Polypharmacy
- [ ] Other, please explain.

c. Please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).

Require PA for all sedatives (e.g. sedative hypnotics, hypnotics-melatonin agonists) except melatonin in children and adolescents. Melatonin is not covered for adults over 18 years of age.

If *"No,"* please continue.

d. Does your state plan on implementing an antianxiety/sedative monitoring program in the future?

◯ Yes, please specify when you plan on implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.

◯ No, please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.

IX. INNOVATIVE PRACTICES

1. Does your state participate in any **demonstrations** or have any **waivers** to allow importation of certain drugs from Canada or other countries that are versions of FDA-approved drugs for dispensing to Medicaid beneficiaries?

   ○ Yes, please explain.

   ◉ No

2. **Summary 5 – Innovative Practices**

   Innovative Practices Summary 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 PA, continuing education programs).

In response to the federal Centers for Medicare & Medicaid Services (CMS) telling the Oregon Health Authority (OHA) to phase out their 1115 waiver authority allowing the use the Prioritized List of Health Services - which helps determine what OHP covers - a substantial focus of the DUR Board's priorities this reporting period focused on the Benefit Update Project (BUP). Continued focus was given to updating all PA criteria to support individualized review for members younger than 21 years of age who have an unfunded diagnosis (a diagnosis located below the funding line of the Oregon Prioritized List of Health Services which will no longer be enforced effective January, 1, 2027), to evaluate on a case-by-case basis whether the requested medication is medically appropriate and necessary as required under the Expanded coverage of Early Periodic Screening Diagnosis and Treatment (EPSDT). These updated EPSDT criteria will serve as the coverage pathway when the Prioritized List is phased out. Additionally, the DUR Board focused on evaluating the evidence for therapeutic drug classes which had not previously been reviewed and made recommendations for inclusion on the Preferred Drug List (PDL) along with implementation and updates to utilization controls.The Oregon Medicaid FFS program continued to focus on our Antipsychotic Denials for Children Report which identifies children with recent denied claims or denied PAs for antipsychotics. Outreach was performed and faxed notifications were sent to engage their prescribers, in addition to the oversight performed for children in Foster CareMore frequent audits were performed which identified inappropriate units being billed on practitioner administered drug (PAD) claims and subsequent missed rebates. Incorrect billing for Medicare claims were identified that needed to be reversed and CCOs were identified that were not paying the tribal all-inclusive rate (AIR) and corrected their reimbursement practices. A third-party liability (TPL) tracking tool was developed to identify use of OCC=3 to facilitate engagement with pharmacies and prescribers to ensure Medicaid is payer of last resort.

X. MANAGED CARE PROGRAMS (MCPs)

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

   16 MCP(s) (Insert the number of MCPs in the space provided including 0 if none)

   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

   If "Partial," please check what categories of medications are carved out of managed care benefits and handled by your FFS program:

   - [ ] Mental health medications
   - [ ] MAT
   - [ ] Opioids
   - [ ] Clotting factors
   - [ ] Other, please specify the drug categories.

3. Contract updates between state and MCPs addressing DUR provisions in Section 1004 Support for Patients and Communities Act are required based on 1902(oo). If covered outpatient drugs are included in an MCP's covered benefit package, has the state updated their MCPs' contracts for compliance with Section 1004 of the SUPPORT for Patients and Communities Act?

   - (●) Yes, contracts are updated to address each provision. Please specify effective date: 01/01/2020
   - ( ) No, contracts are not updated, please explain why not.

a. Is the state complying with federal law and monitoring MCP compliance on the SUPPORT for Patients and Communities Act provisions?

(●) Yes, state is complying with federal law and monitoring MCP compliance on SUPPORT for Patients and Communities Act provisions. Please explain monitoring activities.

Oregon reviews all completed CMS annual surveys from MCPs and compares responses to state and federal expectations. If a response raises a compliance concern, Oregon's Medicaid agency (the Oregon Health Authority, or "OHA") investigates and requires corrective action as appropriate. OHA also meets with MCP pharmacy Directors and representatives in even-numbered months to discuss DUR and other topics relevant to pharmacy program operations and policies. This is often a good opportunity to share best practices and operational challenges. While implementing the initial minimum standards requirement from the SUPPORT Act and during implementation of the related CMS final rules, MCPs completed surveys that detail their practices. Finally, OHA reviews all member letter templates drafted by MCPs. These are routed to subject matter experts for policy review.

( ) No, please explain why not.

4. Does the state use a single PBM/Pharmacy Benefit Administrator (PBA) if the MCP has a drug benefit?

( ) Yes
(●) No
( ) N/A

5. Does the state set requirements for the MCP's pharmacy benefit (i.e., 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.

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If *"No,"* does your state plan to set standards in the future?

- ○ Yes
- ◉ No, please explain.

Oregon sets statewide minimum standards that all MCPs must meet, but these allow some flexibility in specificity how standards are met. Oregon periodically reviews and compares coverage policies on an ad-hoc basis.

6. Is the RetroDUR program operated by the state, by the MCPs or does your state use a combination of state interventions as well as individual MCP interventions?

- ○ State operated
- ◉ MCP operated
- ○ State uses a combination of state interventions as well as individual MCP interventions

7. Indicate how the state oversees the FFS and MCP RetroDUR programs? Please explain the oversight process.

Oregon reviews all completed CMS annual surveys from FFS and MCPs and compares responses to state and federal expectations. If a response raises a compliance concern, OHA investigates and requires corrective action as appropriate. In addition, OHA meets with MCP pharmacy Directors and representatives in even-numbered months to discuss DUR and other topics relevant to pharmacy program operations and policies. Finally, OHA and the Oregon FFS Pharmacy & Therapeutics Committee review quarterly DUR reports for the FFS program. The Committee discusses the reports and recommends changes or follow-up reporting when appropriate.

8. How does the state ensure MCP compliance with DUR requirements described in Section 1927(g) of the Act and 42 C.F.R part 456, subpart K?

Oregon reviews each completed CMS annual survey and compares responses to state and federal expectations. If a response raises a compliance concern, OHA investigates and requires corrective action as appropriate. MCP contracts require implementation of a DUR program as described in Section 1927(g), 42 CFR 438.2(s)(4)-(5) and 42 CFR Part 456, Subpart K. MCPs are required to maintain policies and procedures for their DUR programs and provide these policies and procedures when requested. In addition, OHA meets with MCP pharmacy Directors and representatives in even-numbered months to discuss DUR and other topics relevant to pharmacy program operations and policies.

9. Did **all** of your managed care programs submit their DUR reports?

- (●) Yes
- ( ) No, please explain why not.

XI. EXECUTIVE SUMMARY

Executive Summary should provide a brief overview of your program. It should describe FFY 2025 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCP) initiatives.

Drug Use Review (DUR) is a program designed to measure and assess the proper utilization, quality, therapy, medical appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program includes, but is not limited to, education in relation to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse. The DUR Board's priorities this reporting period focused on implementation and modification of prior authorization criteria in the fee-for-service (FFS) program to ensure medically appropriate use. Drug use evaluations, and targeted strategies were undertaken to identify and correct inappropriate billing and improve rebate collection. Continued focus was given to identify children with recent denied claims or denied PAs for antipsychotics. Outreach was performed and faxed notifications were sent to engage their prescribers.Continued focus was given to updating all PA criteria to support individualized review for members younger than 21 years of age who have an unfunded diagnosis located below the funding line of the Oregon Prioritized List of Health Services which will no longer be enforced effective January 1, 2027. These case-by-case evaluations performed to evaluate whether the requested medication is medically appropriate and necessary as required under the Expanded coverage of Early Periodic Screening Diagnosis and Treatment (EPSDT) will serve as the coverage pathway when the Prioritized List is phased out. Additionally, the DUR Board focused on evaluating the evidence for therapeutic drug classes which had not previously been reviewed and made recommendations for inclusion on the Preferred Drug List (PDL) along with implementation and updates to utilization controls.The Oregon Health Authority (OHA) worked closely with contracted managed care entities (Coordinated Care Organizations, or "CCOs") to continue to their preparations for the Benefit Update Project.