Regular Meeting of the

Santa Clara County Health Authority
Pharmacy and Therapeutics (P&T) Committee

Thursday, June 17, 2021, 6:00 - 8:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference
(408) 638-0968
Meeting ID: 854 0622 0567
Passcode: **SCFHP2021**
https://us06web.zoom.us/j/85406220567

AGENDA

1.	**Roll Call / Establish Quorum**	Dr. Lin	6:00	5 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Committee reserves the right to limit the duration of the public comment period to 30 minutes.	Dr. Lin	6:05	5 min
3.	**Open Meeting Minutes** Review Santa Clara Family Health Plan (SCFHP) 1Q 2021 P&T Open Session Minutes. **Possible Action:** Approve SCFHP P&T Open Session Minutes	Dr. Lin	6:10	2 min
4.	**Standing Agenda Items**			
	a. Chief Medical Officer Health Plan Updates	Dr. Nakahira	6:12	5 min
	b. Medi-Cal Rx Update	Dr. Huynh	6:17	1 min
	c. Grievance & Appeals Report – 1Q 2021	Mr. Breakbill	6:18	5 min
	d. Plan/Global Medi-Cal Drug Use Review	Dr. Otomo	6:23	4 min
	i. Drug Utilization Evaluation Update			
	ii. DHCS DUR Annual Survey			
	e. Emergency Supply Report – 2Q 2020	Dr. Nguyen	6:27	2 min

Adjourn to Closed Session

Pursuant to Welfare and Institutions Code Section 14087.36 (w)

5.	**Closed Meeting Minutes** Review SCFHP 1Q 2021 P&T Closed Session Minutes. **Possible Action:** Approve SCFHP P&T Closed Session Minutes	Dr. Lin	6:29	2 min
6.	**Metrics & Financial Updates**			
	a. Membership Report	Dr. Nakahira	6:31	3 min
	b. Pharmacy Dashboard	Dr. Otomo	6:34	2 min
	c. Drug Utilization & Spend – 1Q 2021	Dr. McCarty	6:36	5 min

7.	**Discussion and Recommendations for Changes to SCFHP's Medical Benefit Drug Prior Authorization Grid** **a.** Medical Benefit Drug PA Grid Modifications **Possible Action:** Approve Medical Benefit Drug Prior Authorization Grid Addition and Modification Recommendations	Dr. Otomo	6:41	3 min
8.	**Discussion and Recommendations for Changes to SCFHP's Cal MediConnect Formulary & Coverage Determination Criteria** **a.** Pharmacy Benefit Manager 1Q 2021 P&T Minutes **b.** Pharmacy Benefit Manager 2Q 2021 P&T Part D Actions **Possible Action:** Approve MedImpact Minutes & Actions	Dr. McCarty	6:44	3 min
9.	**Discussion and Recommendations for Changes to SCFHP's Medi-Cal Formulary & Prior Authorization Criteria**			
	a. Old Business/Follow-Up	Dr. Lin	6:47	1 min
	b. Formulary Modifications **Possible Action:** Approve Formulary Addition and Modification Recommendations	Dr. Otomo	6:48	3 min
	c. Fee-for-Service Contract Drug List Comparability **Possible Action:** Approve CDL Comparability Formulary Recommendations	Dr. McCarty	6:51	3 min
	d. Prior Authorization Criteria	Dr. Nguyen	6:54	5 min

i. **New/Revised Criteria**

1. Adcirca (tadalafil)
2. Tecfidera (dimethyl fumarate)
3. Amitiza (lubiprostone)
4. Brand Name
5. Copaxone (glatiramer acetate)
6. Gilenya (fingolimod)
7. Humira (adalimumab)

ii. **Annual Review**

1. Androgel (testosterone gel)
2. Ciprodex (ciprofloxacin/dexamethasone)
3. Diabetic Supplies
4. Dovonex (calcipotriene)
5. Elmiron (pentosan polysulfate)
6. Exelon (rivastigmine)
7. Hycet (hydrocodone/acetaminophen sol)
8. Intron A (interferon alfa-2b)
9. Lovaza (omega-3 acid ethyl esters)
10. Lysteda (tranexamic acid)
11. Makena (hydroxyprogesterone caproate)
12. Malarone (atovaquone/proguanil)
13. Marinol (dronabinol)
14. Mavyret (glecaprevir/pibrentasvir)
15. Mycobutin (rifabutin)
16. Nebupent (pentamidine)
17. Oral liquids – Non-formulary
18. Pain Medications – Terminally Ill
19. Provigil (modafinil)
20. Reauthorization

21. Restasis, Cequa (cyclosporine)
22. Revatio (sildenafil)
23. Santyl (collagenase)
24. Sporanox (itraconazole)
25. Symlin (pramlintide)
26. Tymlos (abaloparatide)
27. Viroptic (trifluridine)
28. Xenazine (tetrabenazine)
29. Hepatitis C
30. Rhopressa (netarsudil)
31. Oncology
32. Epclusa (sofosbuvir/velpatasvir)

Possible Action: Approve PA Criteria Recommendations

10. New Drugs and Class Review

a.	S1P Receptor Modulators – Multiple Sclerosis	Dr. Le	6:59	10 min
b.	Pulmonary Arterial Hypertension	Dr. McCarty	7:09	50 min
c.	Oral Azole Antifungals			
d.	Actinic Keratosis			
e.	Farxiga – Chronic Kidney Disease			
f.	New Entities – Tepmetko, Qelbree			
g.	New Formulations – Vesicare LS, Bronchitol, Elepsia XR, Roszet			
h.	New Indications – Gocovri, Actemra, Praluent			
i.	New & Expanded Indications – *Informational Only*			

Possible Action: Approve New Drug and Class Recommendations

Reconvene in Open Session

11. Discussion Items

a.	New and Generic Pipeline	Dr. McCarty	7:59	1 min

12. Adjournment Dr. Lin 8:00

Next meeting Thursday September 16, 2021

Notice to the Public—Meeting Procedures

- Persons wishing to address the Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Nancy Aguirre 48 hours prior to the meeting at 408-874-1835.
- To obtain a copy of any supporting document that is available, contact Nancy Aguirre at 408-874-1835. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.

This agenda and meeting documents are available at www.scfhp.com

Santa Clara Family Health Plan™

Pharmacy & Therapeutics Committee

OPEN MEETING MINUTES

Regular Meeting of the

Santa Clara County Health Authority

Pharmacy & Therapeutics Committee

Thursday, March 18, 2021, 6:00 PM – 8:00 PM

Santa Clara Family Health Plan

6201 San Ignacio Ave, San Jose, CA 95119

Minutes (Open) - Draft

Members Present
Jimmy Lin, MD, Chair
Ali Alkoraishi, MD
Hao Bui, BS, RPh
Dang Huynh, PharmD, Director of Pharmacy and UM
Laurie Nakahira, DO, Chief Medical Officer
Peter Nguyen, DO
Jesse Parashar-Rokicki, MD

Members Absent
Xuan Cung, PharmD
Dolly Goel, MD
Narinder Singh, PharmD

Staff Present
Duyen Nguyen, PharmD, Clinical Pharmacist
Tami Otomo, PharmD, Clinical Pharmacist
Charlene Luong, Manager, Grievance & Appeals
Nancy Aguirre, Administrative Assistant

Others Present
Amy McCarty, PharmD, MedImpact

1. **Roll Call**

   Jimmy Lin, MD, Chair, called the meeting to order at 6:06 pm. Roll call was taken and a quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   The 4Q2020 P&T Committee Open meeting minutes were reviewed.

   It was moved, seconded and the open minutes of the December 17, 2020 P&T meeting were **unanimously approved.**

   Motion: Dr. Alkoraishi
   Second: Dr. Nakahira
   Ayes: Ms. Bui, Dr. Huynh, Dr. Lin, Dr. Nguyen, Dr. Parashar-Rokicki,
   Absent: Ms. Cung, Dr. Goel, Dr. Singh

4. Standing Agenda Items

a. Chief Medical Officer Health Plan Updates

Laurie Nakahira, DO, Chief Medical Officer (CMO), presented the CMO Health Plan Updates. SCFHP is currently in the Department of Health Care Services (DHCS) audit, which started on March 8, 2021 and will close tomorrow.

Dr. Nakahira announced a staffing change within the Case Management (CM) department. Raman Singh resigned as CM Director on March 10, 2020. Angela Chen, Utilization Management (UM) Manager, is CM certified and on the Board of CM Association in San Jose, CA. Ms. Chen has accepted the interim CM Director role.

Dr. Nakahira reported that Santa Clara County is currently in the red tier. There are currently three COVID-19 vaccines available under U.S. Food and Drug Administration (FDA) emergency use authorizations (EUA): Pfizer, Moderna, and Johnson & Johnson (J&J). The Santa Clara County Public Health Department would like to administer the one-dose J&J vaccine to individuals who may have difficulty with two vaccine doses (e.g., homebound, incarcerated), and SCFHP will be working with the county on this.

b. Annual P&T Charter Review

Dang Huynh, PharmD, Director, Pharmacy & Therapeutics and UM presented the annual P&T Charter. There were no revisions made.

It was moved, seconded and the P&T Charter was **unanimously approved**.

Motion: Dr. Lin
Second: Dr. Nguyen
Ayes: Dr. Alkoraishi, Ms. Bui, Dr. Huynh, Dr. Nakahira, Dr. Parashar-Rokicki,
Absent: Ms. Cung, Dr. Goel, Dr. Singh

c. Medi-Cal Rx Update

Dr. Huynh presented the Medi-Cal (MC) Rx Update. The go-live date of April 1, 2021 was postponed due to discussions of potential conflict of interest, as Centene purchased Magellan for 2.2 billion dollars and also owns Health Net. DHCS will provide an update in May 2021.

d. Grievance & Appeals Report – 4Q 2020

Charlene Luong, Manager, Grievance & Appeals (G&A) presented the G&A Report for 4Q 2020. Ms. Luong reviewed the MC and Cal MediConnect (CMC) appeals by volume and disposition, as well as the appeal overturn rationale and uphold rationale.

e. Annual Policy Review

Dr. Huynh presented the following pharmacy policies for annual review and reported that no changes were made:

i. PH.01 Pharmacy and Therapeutics Committee
ii. PH.02 Formulary Development and Guideline Management
iii. PH.03 Prior Authorization
iv. PH.04 Pharmacy Clinical Programs and Quality Monitoring
v. PH.05 Continuity of Care for Pharmacy Services
vi. PH.06 Pharmacy Communications
vii. PH.07 Drug Recalls
viii. PH.08 Pain Management Drugs for Terminally Ill
ix. PH.09 Medications for Members with Behavioral Health Conditions
x. PH.11 340B Program Compliance
xi. PH.14 Medications for Cancer Clinical Trial

It was moved, seconded and the policies PH.01, PH.02, PH.03, PH.04, PH.05, PH.06, PH.07, PH.08, PH.09, PH.11, and PH.14 were **unanimously approved**.

Motion: Dr. Alkoraishi
Second: Dr. Nguyen
Ayes: Ms. Bui, Dr. Huynh, Dr. Lin, Dr. Nakahira, Dr. Parashar-Rokicki,
Absent: Ms. Cung, Dr. Goel, Dr. Singh

f. Plan/Global Medi-Cal Drug Use Review
Tami Otomo, PharmD, Clinical Pharmacist, shared the results from SCFHP's quarterly retrospective Drug Use Evaluation (DUE) program. For Q12021, the focus for both MC and CMC was Coronary Artery Disease, specific to members with a history of an inpatient hospitalization and at least one cardiovascular risk factor. SCFHP identified that these members may benefit from a statin to reduce morbidity and/or mortality.

Dr. Otomo shared that the providers of the impacted members will receive a letter in the mail regarding this program.

g. Emergency Supply Report – 1Q 2020
Duyen Nguyen, PharmD, Clinical Pharmacist, presented the 1Q 2020 Emergency Supply Report. The approved claims for antibiotics were appropriate. For denied claims, chart notes were requested. One member had a denied claim for cefixime 400mg capsule. This was identified as a gap and a point-of-sale message will be implemented on cefixime informing the pharmacy that cefdinir is a formulary alternative. There was another case where a member's emergency room chart note did not mention any antibiotics upon discharge and mentioned that the member did not have a primary or family physician. This case was forwarded to the plan's Quality Department for further review.

Adjourned to Closed Session at 6:30 p.m.
Pursuant to Welfare and Institutions Code Section 14087.36 (w)

5. Closed Meeting Minutes

The 4Q2020 P&T Committee Closed meeting minutes were reviewed.

It was moved, seconded and the closed minutes of the December 17, 2020 P&T meeting were **unanimously approved**.

Motion: Dr. Nguyen
Second: Dr. Nakahira
Ayes: Dr. Alkoraishi, Ms. Bui, Dr. Huynh, Dr. Lin, Dr. Parashar-Rokicki
Absent: Dr. Cung, Dr. Goel, Dr. Singh

6. Metrics and Financial Updates

a. Membership Report
Dr. Nakahira reviewed the Membership Report for January to March 2021..

b. Pharmacy Dashboard
Dr. Otomo reviewed the Pharmacy Dashboard for October 2020 to February 2021.

c. Pharmacy Member Portal Stats – 2H 2020
Dr. Huynh presented the Pharmacy Member Portal Stats for the second half of 2020.

d. Drug Utilization & Spend – 4Q 2020
Amy McCarty, PharmD, MedImpact, presented the Drug Utilization and Spend for 4Q 2020.

7. Discussion and Recommendations for Changes to SCFHP's Cal MediConnect Formulary & Coverage Determination Criteria

a. Pharmacy Benefit Manager 4Q 2020 P&T Minutes
Dr. McCarty referenced the Pharmacy Benefit Manager 4Q 2020 P&T Minutes included in the meeting packet.

b. Pharmacy Benefit Manager 1Q 2021 P&T Part D Actions
Dr. McCarty reviewed the Pharmacy Benefit Manager 1Q 2021 P&T Part D Actions.

It was moved, seconded and the Pharmacy Benefit Manager 4Q 2020 P&T Minutes and 1Q 2021 P&T Part D Actions were **unanimously approved**.

Motion: Dr. Huynh
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Ms. Bui, Dr. Nakahira, Dr. Parashar-Rokicki,
Absent: Dr. Cung, Dr. Goel, Dr. Singh

8. Discussion and Recommendations for Changes to SCFHP's Medi-Cal and Prior Authorization Criteria

a. Old Business/Follow-Up

Dr. Huynh reported there were no old business items to report and/or follow-up.

b. Formulary Modifications
Dr. Otomo presented the changes made to the Medi-Cal formulary since the last P&T Committee meeting in December 2020.

It was moved, seconded and the Medi-Cal Formulary Modifications were **unanimously approved**.

Motion: Dr. Alkoraishi
Second: Dr. Nguyen
Ayes: Ms. Bui, Dr. Huynh, Dr. Lin, Dr. Nakahira, Dr. Parashar-Rokicki,
Absent: Dr. Cung, Dr. Goel, Dr. Singh

c. Fee-for-Service Contract Drug List Comparability
Dr. McCarty reviewed the Fee-for-Service (FFS) Contract Drug List (CDL) Comparability for MC.

It was moved, seconded and the Fee-for-Service Contract Drug List Comparability proposed actions were **unanimously approved**.

Motion: Dr. Huynh
Second: Dr. Nguyen
Ayes: Dr. Alkoraishi, Ms. Bui, Dr. Lin, Dr. Nakahira, Dr. Parashar-Rokicki
Absent: Dr. Cung, Dr. Goel, Dr. Singh

d. Prior Authorization Criteria
Dr. Nguyen reviewed the Prior Authorization Criteria.

i. <u>New or Revised Criteria</u>
1. Movantik (Naloxegol) – *new criteria.*

ii. <u>Annual Review</u>
1. Letairis (Ambrisentan) – *no changes*
2. Jadenu (Deferasirox) – *no changes*
3. Vumerity (Diroximel fumarate) – *no changes*
4. Gukenya (Fingolimod) – *no changes*
5. General utilization management – *no changes*
6. Copaxone (Glatiramer acetate) – *no changes*
7. Avonex & Rebif (Interferon beta-1a) – *no changes*
8. Savella (Milnacipran) – *no changes*
9. Opioid – Reauthorization – *no changes*
10. Oxycontin (Oxycodone) – *no changes*

11. Evista (Raloxifene) – *no changes*

It was moved, seconded and the Prior Authorization Criteria was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Nguyen
Ayes: Dr. Alkoraishi, Ms. Bui, Dr. Huynh, Dr. Nakahira, Dr. Parashar-Rokicki
Absent: Dr. Cung, Dr. Goel, Dr. Singh

9. New Drugs and Class Reviews

a. Nexletol & Nexlizet – Hyperlipidemia
Dr. McCarty presented adenosine triphosphate-citrate lyase (ACL) inhibitors: Nexletol and Nexlizet.

b. Aducanumab – Alzheimer's Disease Review
Dr. McCarty presented a new drug for Alzheimer's Disease, aducanumab.

c. COVID-19 Treatments
Dr. McCarty presented the COVID-19 treatments and reviewed the current five treatments with full or conditional approval, including Veklury, Olumiant, bamlanivimab, casirivimab-imdevimab, and etesevimab.

It was moved, seconded and the recommendations for New Drugs and Class Reviews were **unanimously approved.**

Motion: Dr. Huynh
Second: Dr. Nguyen
Ayes: Dr. Alkoraishi, Ms. Bui, Dr. Lin, Dr. Nakahira, Dr. Parashar-Rokicki
Absent: Dr. Cung, Dr. Goel, Dr. Singh

d. <u>Informational Only</u>

i. Ponesimod – Muliple Scierosis
ii. Umbralisib – Lymphoma
iii. Dasiglucagon – Hypoglycemia
iv. New & Expanded Indications
v. New Derivatives, Formulations, & Combinations

Reconvene in Open Session at 7:37 p.m.

10. Discussion Items

a. New and Generic Pipeline
Dr. McCarty reviewed the New and Generic Pipeline. Teplizumab, a drug to delay the development of Type 1 diabetes, is currently under FDA review and projected to come to market in 3Q2021.

Ms. Bui announced her retirement from the P&T Committee after serving the committee since 1997. During her 20+ years of service, Ms. Bui also served 12 years as a Board member on SCFHP's Governing Board. SCFHP thanked Ms. Bui for all her dedication and commitment to the P&T Committee, SCFHP, and the members within the community. Ms. Bui's participation is appreciated and will be missed.

11. Adjournment
The meeting adjourned at 7:54 p.m. The next P&T Committee meeting will be on Thursday, June 17, 2021.

_____ _____
Jimmy Lin, MD, Chair Date

Santa Clara Family Health Plan™

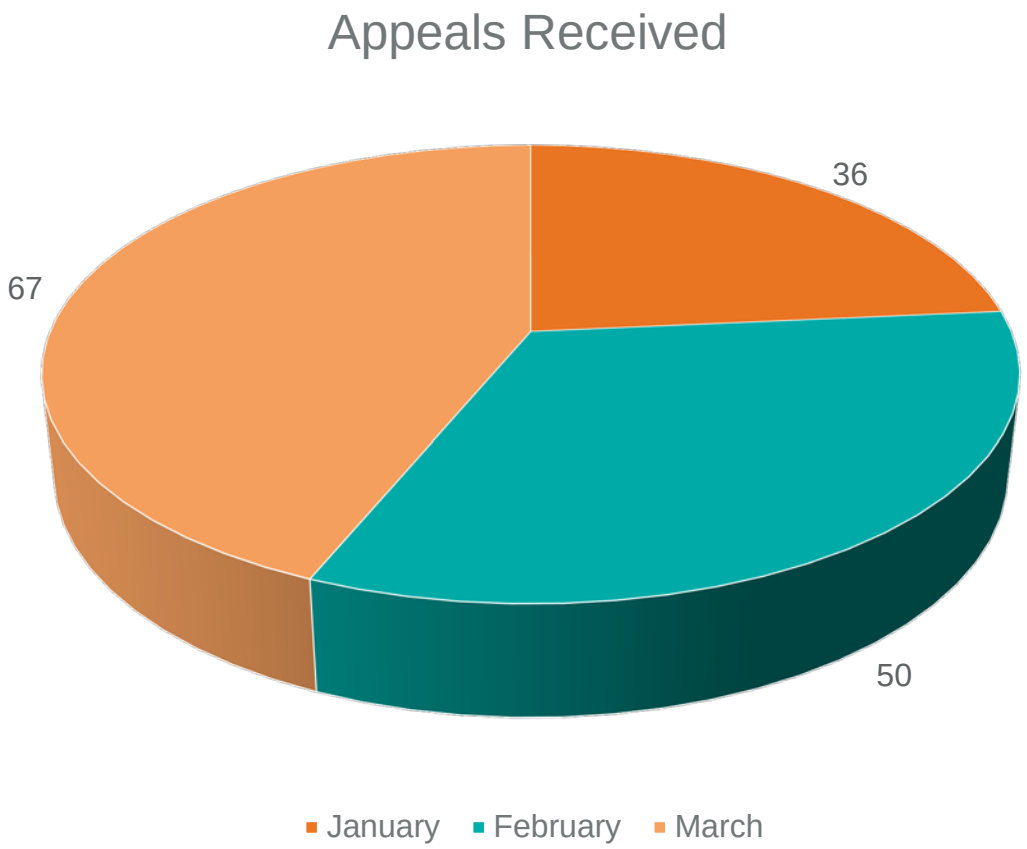
Pharmacy & Therapeutics Committee

STANDING AGENDA ITEMS

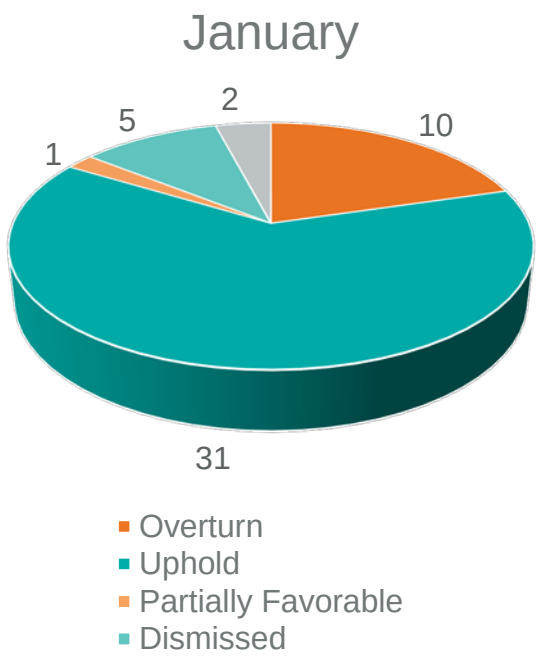
Santa Clara Family Health Plan™

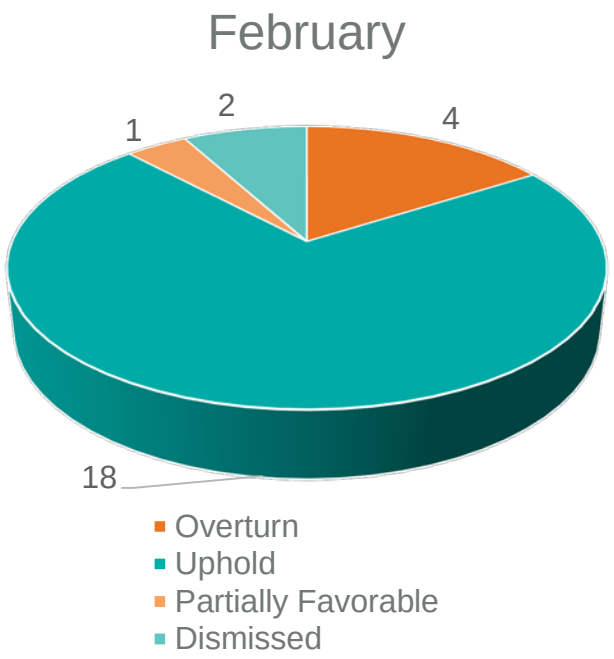
Grievance & Appeals Department
Q1 2021 Reporting

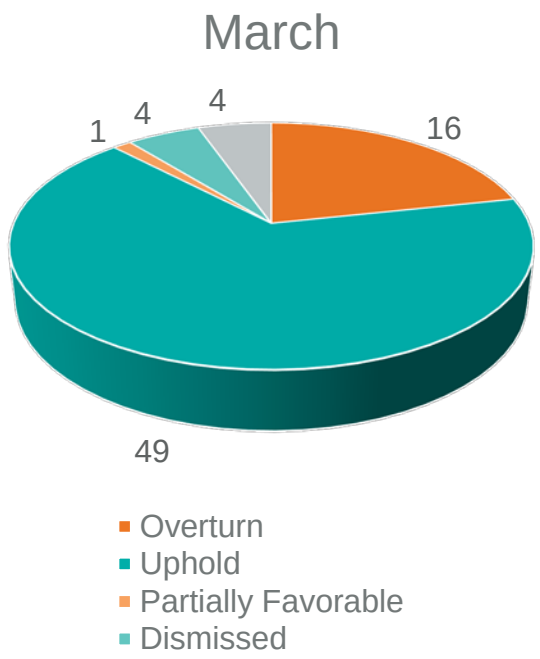
Q1 2021 Medi-Cal Appeals Volume



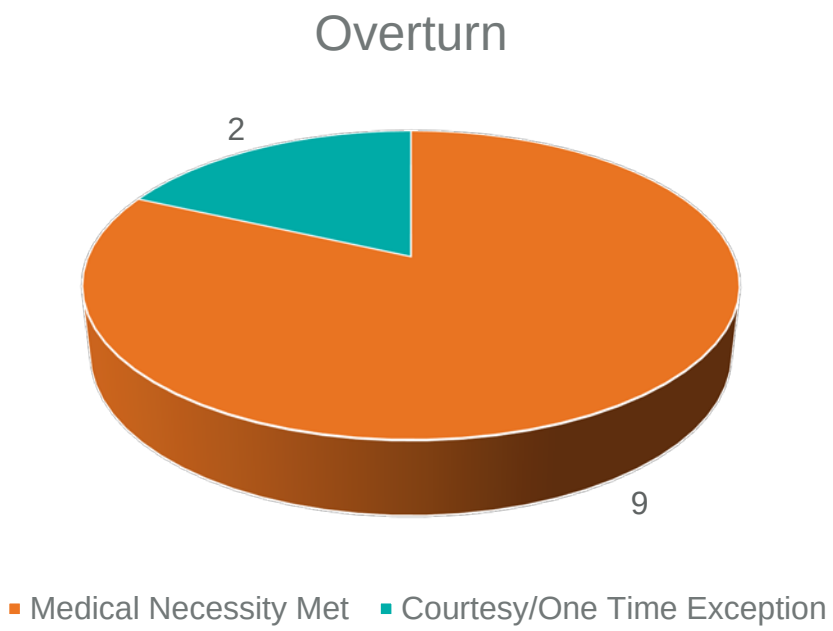
Q1 2021 MC Appeals by Decision

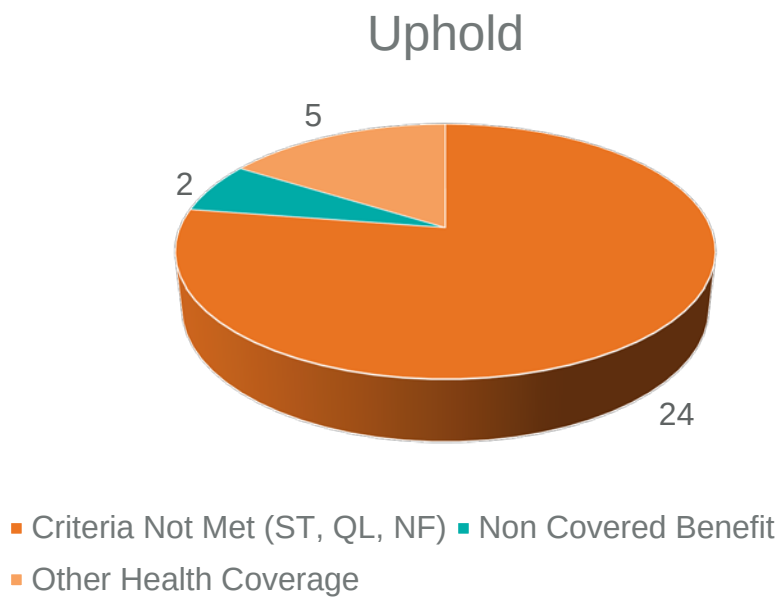




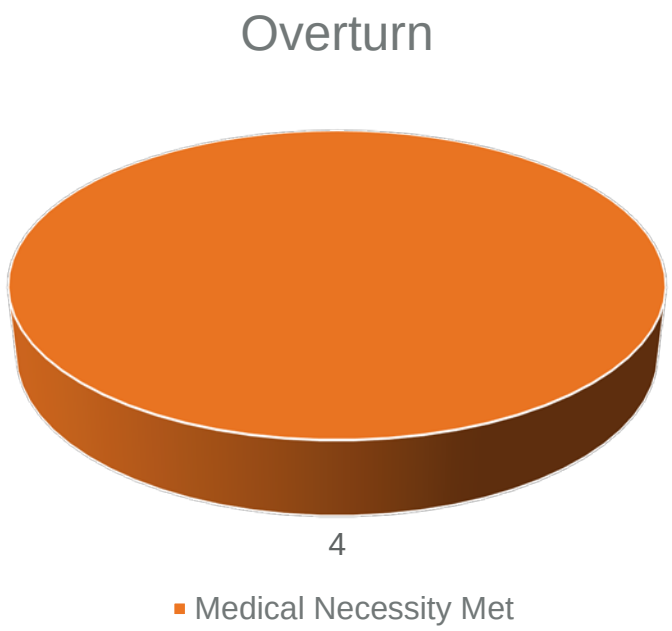


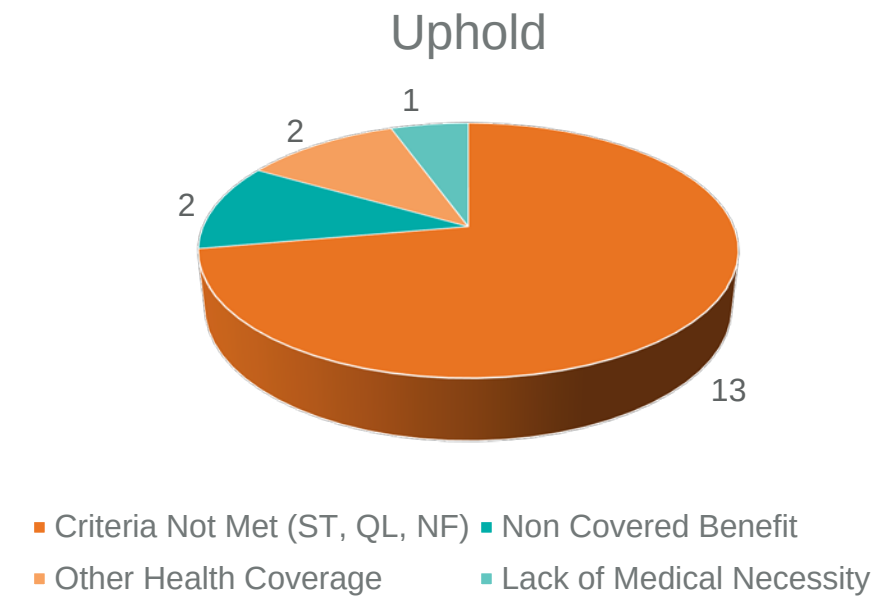
January 2021 MC Appeals by Rationale



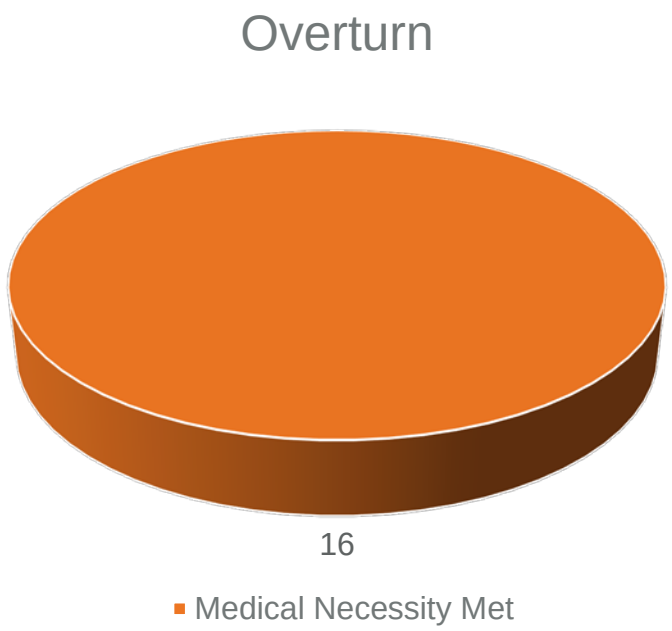


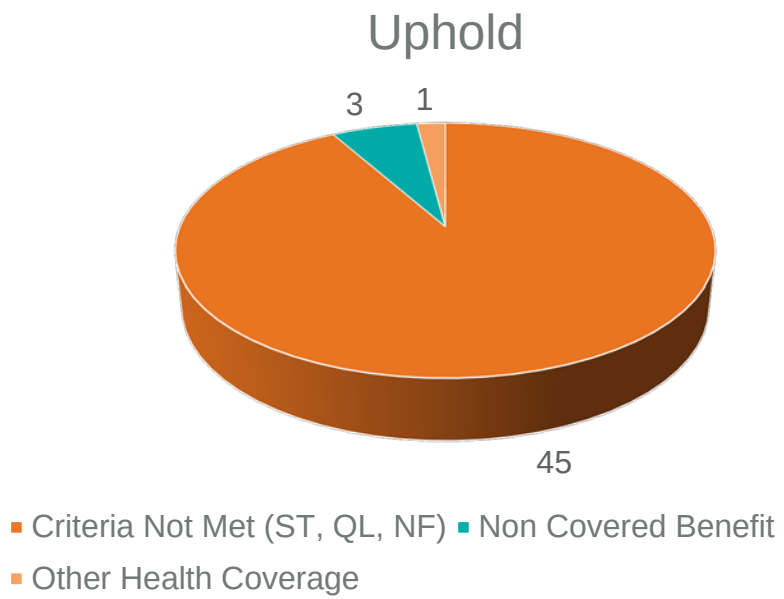
February 2021 MC Appeals by Rationale



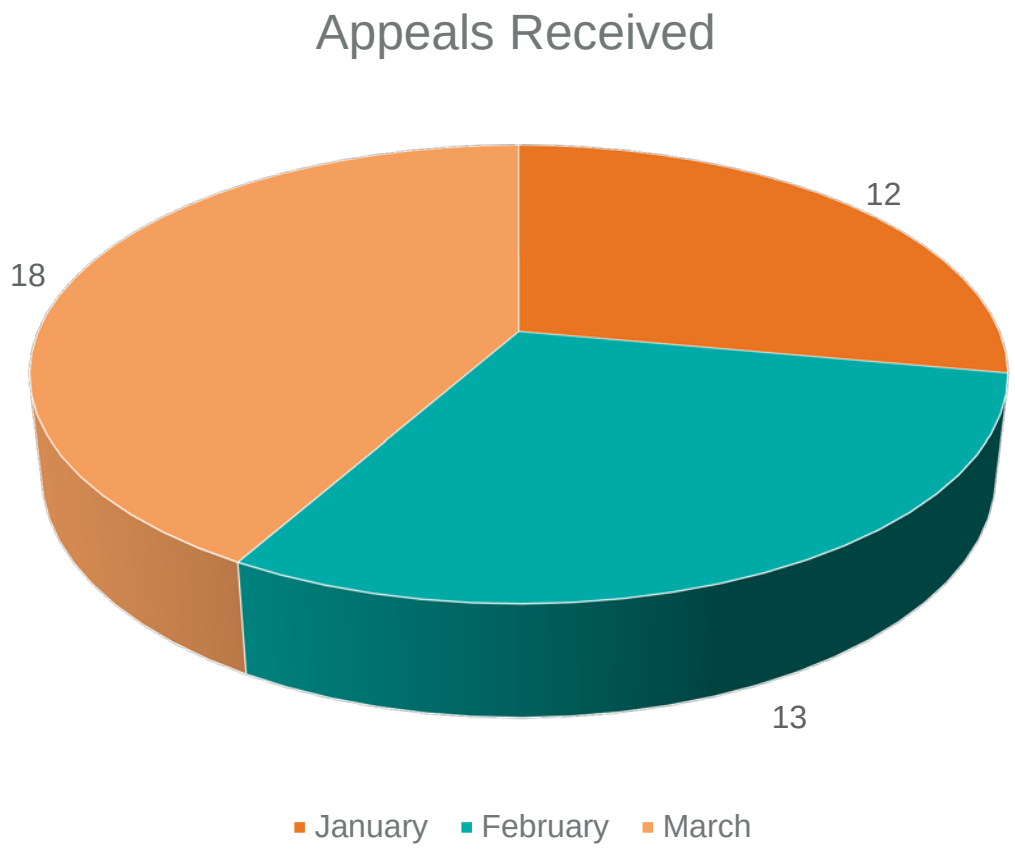


March 2021 MC Appeals by Rationale



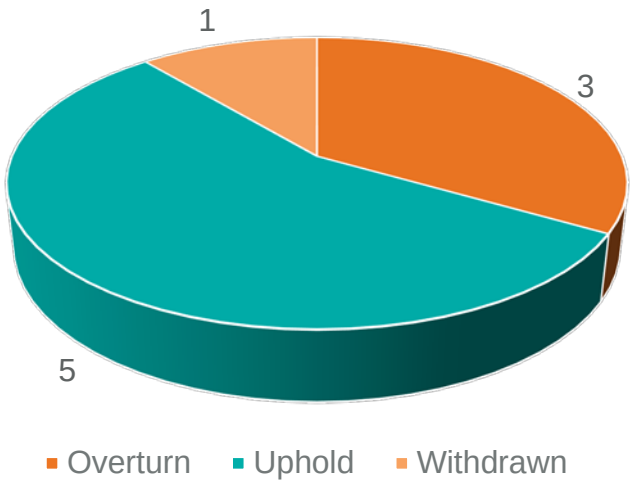


Q1 2021 Cal MediConnect Appeals Volume

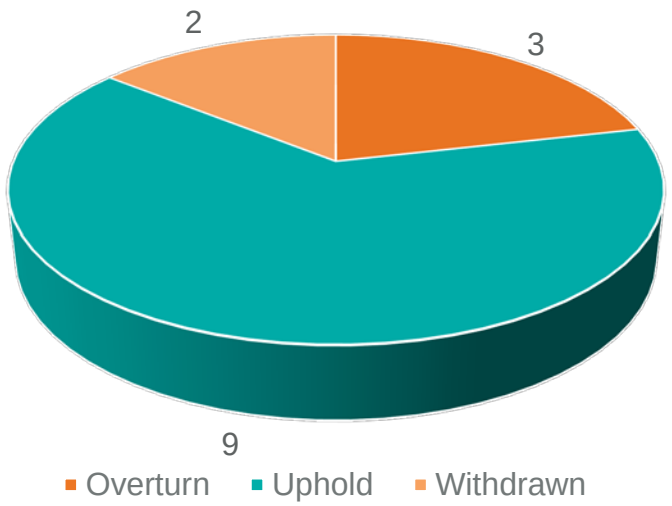


Q1 2021 CMC Appeals by Decision

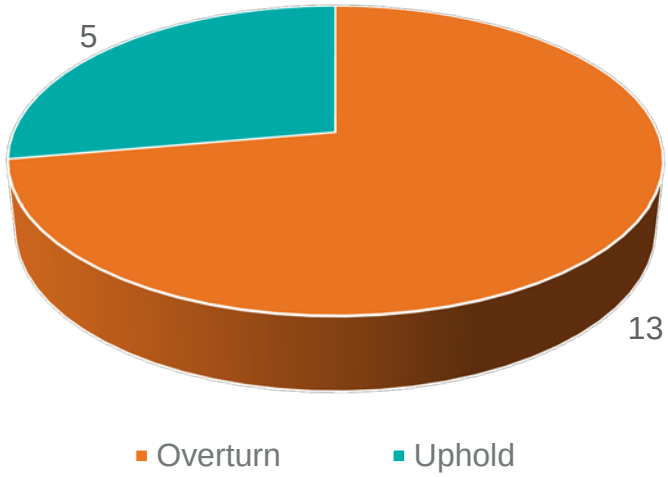
January



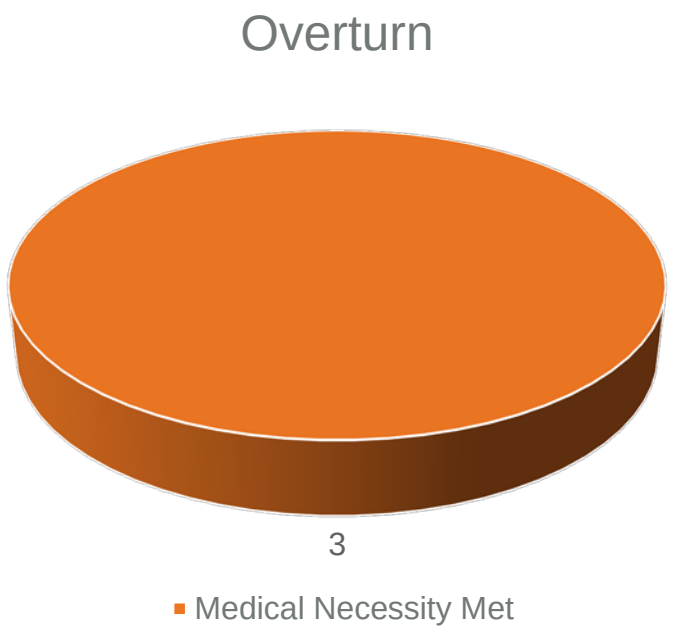
February

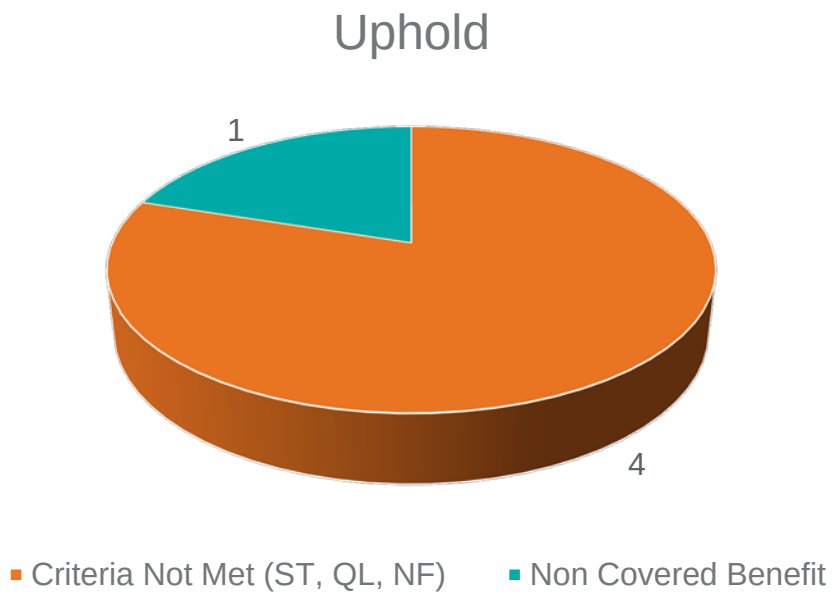


March

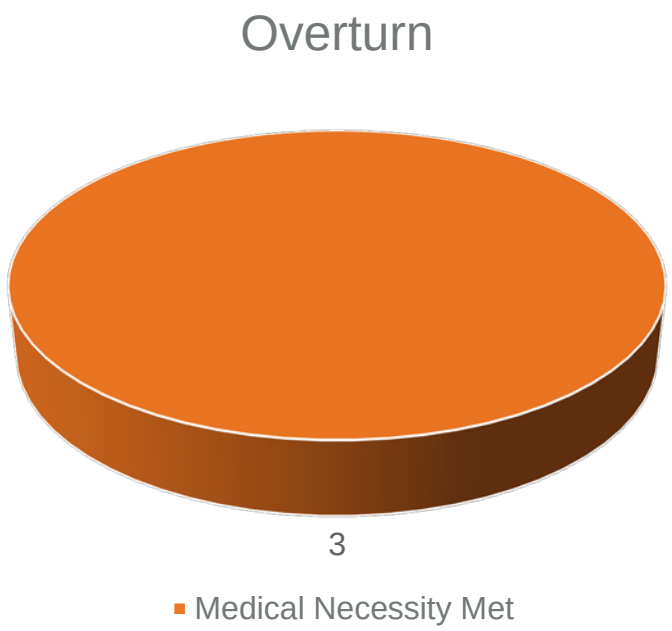


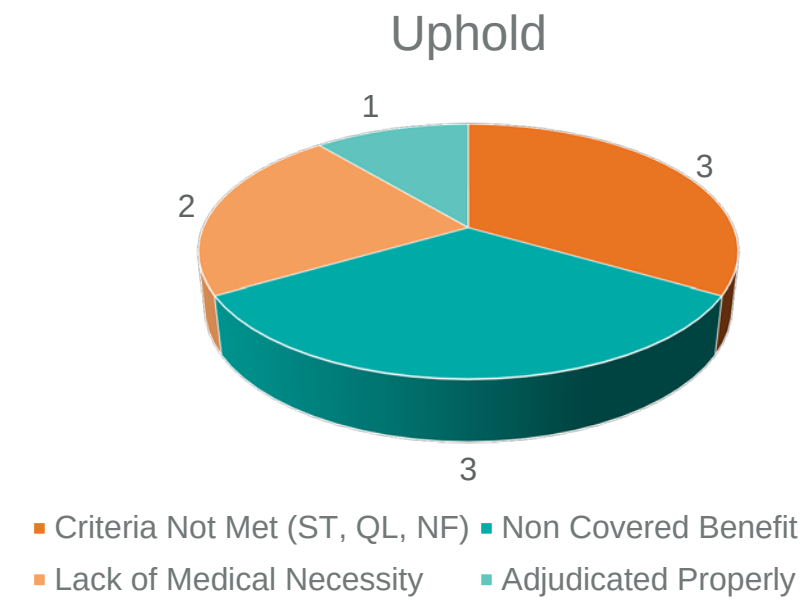
January 2021 CMC Appeals by Rationale



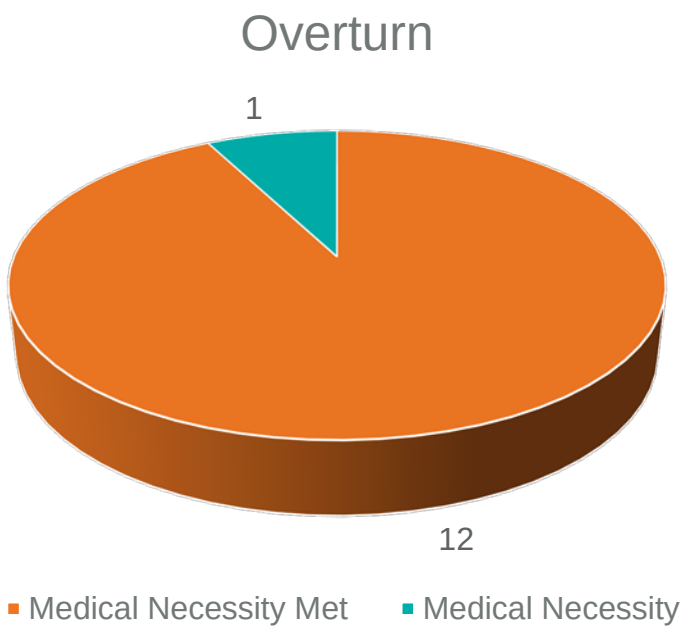


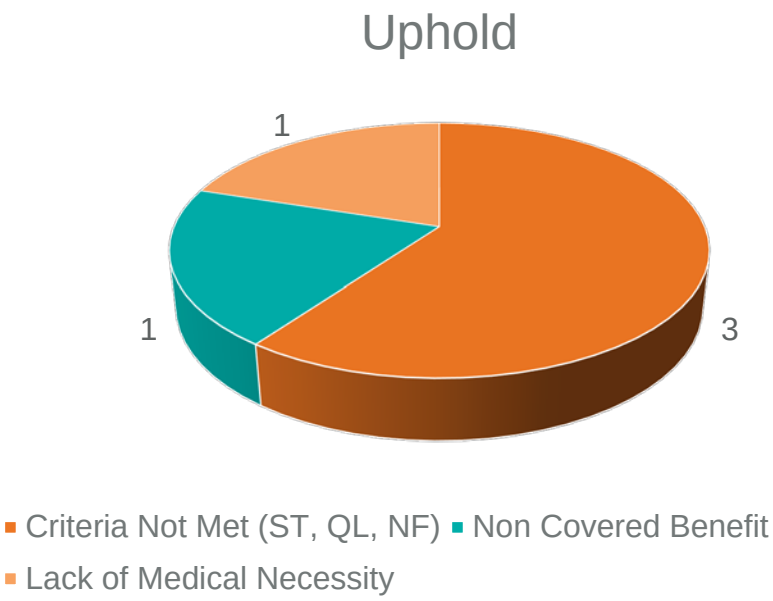
February 2021 CMC Appeals by Rationale





March 2021 CMC Appeals by Rationale





Santa Clara Family Health Plan™

Grievance & Appeals Department

ABOUT THE SURVEY

42 CFR 438.3(s)(4) and (5) require that each Medicaid managed care organization (MCO) must operate a drug utilization review (DUR) program that complies with the requirements described in Section 1927 (g) of the Social Security Act (the Act) and submit an annual report on the operation of its DUR program activities. Such reports are to include: descriptions of the nature and scope of the prospective and retrospective DUR programs; a summary of the interventions used in retrospective DUR and an assessment of the education program; a description of DUR Board activities; and an assessment of the DUR program's impact on quality of care.

Note: Covered Outpatient Drugs (COD) are referenced throughout this survey and refers to participating labelers in the Medicaid Drug Rebate Program (MDRP).

This report covers the period October 1, 2019 to September 30, 2020 and is due for submission to CMS Central Office by no later than June 30, 2021. Answering the attached questions and returning the requested materials as attachments to the report will constitute compliance with the above-mentioned statutory and regulatory requirements.

If you have any questions regarding the DUR Annual Report, please contact your state's Medicaid Pharmacy Program.

IMPORTANT NOTE: Adobe Acrobat Reader must be used to edit the survey. The MCO survey cannot be edited within a browser window.

Pursuant to 42 C.F.R. Subpart A, Section § 438.3 (s), Medicaid managed care programs must submit to CMS an annual report on the operation of its DUR program activities for that Federal Fiscal Year (FFY). Beginning with FFY 2020 surveys, individual managed care plan's survey results will be published online and will be publicly available similar to the FFS surveys which have been published on Medicaid.gov since 2010. **Please confirm and acknowledge there is no proprietary or confidential information submitted in this report by checking the box below:**

☒ I confirm I am aware this survey will be posted online. Confidential and proprietary information has been removed from this survey.

PRA DISCLOSURE STATEMENT (CMS-R-153)

This mandatory information collection (section 4401 of the Omnibus Budget Reconciliation Act of 1990 and section 1927(g) of the Social Security Act) is necessary to establish patient profiles in pharmacies, identify problems in prescribing and/or dispensing, determine each program's ability to meet minimum standards required for Federal financial participation, and ensure quality pharmaceutical care for Medicaid patients. State Medicaid agencies that have prescription drug programs are required to perform prospective and retrospective DUR in order to identify aberrations in prescribing, dispensing and/or patient behavior. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this information collection request is 0938-0659 (Expires: 11/30/2022). Public burden for all of the collection of information requirements under this control number is estimated at 64 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

I. DEMOGRAPHIC INFORMATION

State Abbreviation: CA

MCO Name: SantaClaraHealthPlan

Please note: Name above must match name entered in Medicaid Drug Programs (MDP) DUR system

Program Type: (*See Appendix A*)

Comprehensive MCO + MLTSS

If "Other", please specify.

Medicaid MCO Information

Identify the MCO person responsible for DUR Annual Report preparation.

First Name: Dang

Last Name: Huynh

Email Address: dhuynh@scfhp.com

Area Code/Phone Number: 408-874-1901

On average, how many Medicaid beneficiaries are enrolled monthly in your MCO for this Federal Fiscal Year?

239,626.00 Beneficiaries

II. **PROSPECTIVE DUR (ProDUR)**

1. Indicate the type of your pharmacy point of service (POS) vendor and identify by name.

   ○ State-operated

   ◉ Contractor

   ○ Other organization

   If "Contractor" or "Other organization", please identify by name your pharmacy POS vendor.

   MedImpact Healthcare Services, Inc.

   If "Other", please specify.

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

   ☒ First Data Bank

   ☐ 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 "National Council for Prescription Drug Program (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.

Many ProDUR edits send alert messages that do not require a NCPDP response.

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

◉ Yes

a) How often does your MCO receive reports? Check **all** that apply:

☐ Monthly

☐ Quarterly

☐ Annually

☐ Ad hoc (on request)

☒ Other, please explain.

Biannually

b) Does your MCO follow up with those providers who routinely override with interventions?

○ Yes

By what method does your MCO follow up? Check **all** that apply:

☐ Contact Pharmacy

☐ Refer to Program Integrity (PI) for Review

☐ Other, please explain.

◉ No

○ No, please explain.

5. Early Refill

a) At what percent threshold does your MCO set your system to edit?

i. Non-controlled drugs:

85 %

ii. Schedule II controlled drugs:

90 %

iii. Schedule III through V controlled drugs:

85 %

b) For non-controlled drugs:

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

- ○ Yes
- ○ No
- ◉ Dependent on the medication or situation

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

- ○ Pharmacist
- ○ Prescriber
- ◉ Pharmacist or Prescriber

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

- ○ Yes
- ○ No

c) For controlled drugs:

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

- (●) Yes
- ( ) No

If "Yes", who obtains authorization?

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

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

- ( ) Yes
- ( ) No

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

a) Lost/stolen Rx

- ( ) Yes
- (●) No
- ( ) Overrides are only allowed by a pharmacist through a PA

b) Vacation

- ( ) Yes
- (●) No
- ( ) Overrides are only allowed by a pharmacist through a PA

c) Other, please explain.

Early refills due to lost, stolen, or vacation will deny for refill-too-soon which requires the pharmacist to call the Pharmacy Benefit Manager's pharmacy help desk or the plan for an override. Beneficiaries may also contact the health plan for an override for these reasons.

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

   ○ Yes

   ◉ No

   If "Yes", please explain your edits.

   If "No", does your MCO plan to implement this edit?

   ○ Yes

   ◉ No

8. Does your MCO 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. For drugs not on your MCO's Preferred Drug List (PDL), does your MCO have a documented process (i.e. PA) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?

- (●) Yes

  Check **all** that apply:

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

    The plan uses a documented procedure for prior authorizations. These processes are supported by prior authorization criteria that are reviewed and approved by the plan's Pharmacy and Therapeutics (P&T) Committee.

- ( ) No, please explain.

a) How does your MCO ensure PA criteria is no more restrictive than the FFS criteria and review? Please describe the process.

The plan conducts an annual formulary comparison review against the FFS contract drug list (CDL) in all therapeutic categories. This review includes utilization management criteria. All prior authorization criteria are reviewed by the plan's Pharmacy & Therapeutics (P&T) Committee to ensure drug coverage for medical necessity.

b) Does your program provide for the dispensing of at least a 72-hour supply of CODs in an emergency situation?

◉ Yes

Check **all** that apply:

☐ Real time automated process

☒ Retrospective PA

☒ Other process, please explain.

The plan's emergency situation policy is to provide up to a 72-hour supply of drug. The plan delegates the operational process of emergency supply to MedImpact and its pharmacy network. MedImpact and the pharmacy network follow a documented Medicaid procedure for emergency situations.

○ No, please explain.

10. 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 (*See Appendix B for the list of Drug Names*)

    Column 2 – Top 10 PA Requests by Drug Class (*See Appendix C for Drug Class names*)

    Column 3 – Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD), and Age Edits (AE)) (*See Appendix D for the list of Denial Reasons*)

    Column 4 – Top 10 Drug Names by Amount Paid, report at generic ingredient level (*See Appendix B for the list of Drug Names*)

    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 (*See Appendix B for the list of Drug Names*)

    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 select 'Other' and enter a free form response in the box below. 'Other' is found at the bottom of the list.

Column 1 Top 10 PA Requests by Drug Name, report at generic ingredient level (*See Appendix B for the list of Drug Names*)	Column 2 Top 10 PA Requests by Drug Class (*See Appendix C for Drug Class names*)	Column 3 Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD), and Age Edits (AE)) (*See Appendix D for the list of Denial Reasons*)	Column 4 Top 10 Drug Names by Amount Paid, report at generic ingredient level (*See Appendix B for the list of Drug Names*)	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 (*See Appendix B for the list of Drug Names*)	Column 7 Drugs by Claim Count % of Total Claims (From data in Column 6, determine the % of total claims)
diclofenac	anticonvulsant agents	refill too soon	adalimumab	7.70%	atorvastatin	3.10%
fluticasone	other	product/service not covered - plan/benefit	dulaglutide	6.30%	aspirin	3.10%
	Antineoplastic Systemic Enzyme Inhibitor					
tretinoin	other	product not on formulary	insulin glargine	3.00%	loratadine	3.00%
	Insulins					
cyclosporine	other	days supply	empagliflozin	2.80%	amlodipine	2.40%
	Topical Anti-Inflammatory Steroidal					
tacrolimus	other	patient is not covered	etanercept	2.40%	metformin	2.40%
	Miotics/Other Intraoc. Pressure Reducers					
budesonide	analgesics, narcotic agents		lenalidomide	2.00%	ibuprofen	2.30%
lidocaine	other		rivaroxaban	1.90%	other	2.20%
	Glucocorticoids, Orally Inhaled				Cholecalciferol (Vitamin D3)	
adalimumab	proton pump inhibitor agents		insulin lispro	1.90%	albuterol	2.10%
apixaban	other		beclomethasone	1.80%	fluticasone	1.90%
	Anti-Inflammatory Tumor Necrosis Factor					
gabapentin	other		ustekinumab	1.80%	gabapentin	1.80%
	Antihyperglycemic, DPP-4 Inhibitors					

III. **RETROSPECTIVE DUR (RetroDUR)**

1. Please indicate how your MCO operates and oversees RetroDUR reviews.

- ○ State-operated interventions
- ○ Managed Care executes its own RetroDUR activities
- ○ Pharmacy Benefit Manager (PBM) performs RetroDUR activities
- ○ Combination of MCO RetroDUR interventions and state interventions are performed
- ◉ Other, please explain.

Combination of PBM RetroDUR activities and plan (MCO) RetroDUR interventions, which may be based on state interventions

2. Identify the vendor, by name and type, that performed your RetroDUR activities during the time period covered by this report.

(●) Company

Other

If "Other", please identify by name and type.

MedImpact Healthcare Systems, Inc. (Pharmacy Benefit Manager) and plan (MCO)

( ) Academic Institution, please identify by name and type.

( ) Other Institution, please identify by name and type.

a) Is the RetroDUR vendor the developer/supplier of your retrospective DUR criteria?

( ) Yes, please explain.

(●) No, please explain.

For PBM RetroDUR activities, MedImpact selects RetroDUR criteria based on common drug problems identified in peer reviewed clinical studies and supported by POS data.

For plan (MCO) RetroDUR activities, the plan reviews the state DUR Board's activities and interventions and creates criteria and programs around that, when appropriate. The plan

b) Does your MCO customize your RetroDUR vendor criteria?

( ) Yes

(●) No

( ) Ad hoc based on state-specific needs

3. Who reviews and approves your MCO RetroDUR criteria?

- ○ State DUR Board
- ○ MCO DUR Board
- ○ PBM performs RetroDUR and has a RetroDUR Board
- ○ PBM Pharmacy and Therapeutics (P&T) Board also functions as a DUR Board
- ○ State Pharmacy Director
- ◉ Other, please explain.

MedImpact Healthcare Systems, Inc. (Pharmacy Benefit Manager) and plan (MCO).

MedImpact approves and performs RetroDUR with oversight provided by their Utilization Management Oversight Committee.

The plan presents RetroDUR activities and interventions to the plan's P&T Committee for

4. How often does your MCO perform retrospective practitioner-based education?

- ○ Monthly
- ○ Bi-monthly
- ◉ Quarterly
- ○ Other, please specify:

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

- ☐ Monthly
- ☐ Bi-monthly
- ☒ Quarterly
- ☐ Other, please specify:

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 WebEx training
- ☐ Newsletters or other non-direct provider communications
- ☐ Other, please specify:

5. **Summary 1: RetroDUR Educational Outreach**

Summary 1: RetroDUR Educational Outreach is a year-end summary 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.

Santa Clara Family Health Plan (SCFHP) conducts drug use evaluation (DUE) programs for Medi-Cal members that identify opportunities in drug usage and patterns and provide related education to providers via mailed letters. The DUE program topics are based on Healthcare Effectiveness Data and Information Set (HEDIS) metrics, Centers for Medicare and Medicaid Services (CMS) metrics, and drug trends, including targeted adherence and polypharmacy.

Between October 1, 2019 and September 30, 2020, SCFHP conducted the following retrospective DUE programs for Medi-Cal members:

1. December 2019 - Statin Use in Persons with Diabetes
- Criteria: Identify members whose medication history was suggestive of diabetes and who were not receiving a statin in a 3-month period
- Rationale: Prevent primary atherosclerotic cardiovascular disease in alignment with recommendations in the 2019 American College of Cardiology/American Heart Association (ACC/AHA) Guideline on the Primary Prevention of Cardiovascular Disease (CVD)

2. March 2020 - Coronary Artery Disease
- Criteria: Identify members 40-75 years of age with at least one cardiovascular disease (CVD) risk factor (diabetes, hypertension, or smoking) and not on a statin in a 3-month period
- Rationale: Decrease coronary artery disease adverse events

3. June 2020 - Congestive Heart Failure
- Criteria: Identify members with a heart failure diagnosis and who were prescribed metoprolol succinate, carvedilol, or bisoprolol in a 3-month period and may therefore benefit from an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin II receptor blocker (ARB) to reduce death and morbidity
- Rationale: Decrease congestive heart failure adverse events

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Between October 1, 2019 and September 30, 2020, SCFHP sent the following educational communications to network providers:

1. November 2019 - Medi-Cal: Opioid Safety Point-of-Sale Edits
- Description: Inform providers about implementation of opioid point-of-sale edits to meet requirements outlined in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, specifically the following edits: Opioid Cumulative Dosing, Opioid-Benzodiazepine Concurrent Use, Opioid-Antipsychotic Concurrent Use, Opioid Naive Fill Limit.
- Outreach Delivery Method: Provider newsletter

2. November 2019 - Safety Reminder: Concomitant Anticholinergic and Antipsychotic Use
- Description: Remind providers of the potential adverse effects when anticholinergics and antipsychotics are used concomitantly.
- Outreach Delivery Method: Provider newsletter

3. November 2019 - Immunization Resources and Recommendations
- Description: Remind providers about available immunization resources and encourage providers to ensure patients receive scheduled immunizations and the influenza vaccine.
- Outreach Delivery Method: Provider newsletter

IV. **DUR BOARD ACTIVITY**

1. Does your MCO utilize the same DUR Board as the state FFS Medicaid program or does your MCO have its own DUR Board?

   - (●) Same DUR Board as FFS agency
   - ( ) MCO has its own DUR Board
   - ( ) Other, please explain.

2. **Summary 2: DUR Board Activities Summary**

Summary 2: DUR Board Activities Summary should be a brief descriptive report on DUR activities during the fiscal year reported. Please provide a summary below.

- Indicate the number of DUR Board meetings held.
- List additions/deletions to DUR Board approved criteria.
  a) For ProDUR, list problem type/drug combinations added or deleted.
  b) 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 mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring).

The FFS Agency DUR Board met four times during FFY 2020. Santa Clara Family Health Plan actively participates in the FFS DUR Board with a selected representative who also serves as a DUR Board member. Recommendations offered by the FFS DUR Board and minutes were brought back to the plan for internal distribution and discussion. Selected DUR recommended actions and additional DUR activities were presented at the plan's Pharmacy & Therapeutics Committee Meetings.

FFS DUR Board has established processes for ProDUR and RetroDUR screening and adjustments. SCFHP delegates ProDUR and RetroDUR to PBM, MedImpact Healthcare Systems, Inc. MedImpact provides MCO with supportive DUR services and the related policies and procedures.

Retrospective DUR:
- Statin Use in Persons with Diabetes drug use evaluation
- Coronary Artery Disease drug use evaluation
- Congestive Heart Failure drug use evaluation
- Monitoring opioid cumulative dosing limits
- Monitoring opioid naive fill limits
- Monitoring opioid-benzodiazepine concurrent use
- Monitoring opioid-antipsychotic concurrent use

Prospective DUR:
- Added ProDUR Drug-Disease Contraindication edit for known disease (ICD-10 diagnosis codes)
- Added the following opioid point-of-sale safety edits to meet requirements outlined in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (HR6):
1. Opioid-Naive Edit - If the POS system identifies the beneficiary as opioid naive (defined as no opioid claims in the past 60 days), the beneficiary will be restricted to no more than two opioid prescriptions within a 30 day period.
2. Opioid Cumulative Dosing Soft Edit Rejection - A POS intervention that will deny incoming opioid claim(s) when a beneficiary's daily morphine milligram equivalent (MME) is greater than or equal to

3. Does your MCO have a Medication Therapy Management (MTM) Program?

   ○ Yes

   ◉ No

V. PHYSICIAN ADMINISTERED DRUGS (PAD)

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

1. ProDUR?

   ○ Yes

   ◉ No

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

   ○ Yes

   ◉ No

2. RetroDUR?

   ○ Yes

   ◉ No

   If "No", does your MCO 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

Summary 3: 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.

Santa Clara Family Health Plan (SCFHP) generic utilization percentage may be attributed to point-of-sale generic equivalent substitutions, dispense as written (DAW) restrictions, and formulary management.

1) Policies encouraging generic equivalent substitution for drugs dispensed through SCFHP.

In cases where generic drugs are more cost-effective, SCFHP encourages use of generic drugs. Providers, to the extent permitted by law, shall dispense the lowest cost drug product within the generic drug type in stock, which meets the medical needs of the beneficiary.

California Business and Professions Code Section 4073 states:
(a) “A pharmacist filling a prescription order for a drug product prescribed by its trade or brand name may select another drug product with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name as determined by the United States Adopted Names (USAN) and accepted by the federal Food and Drug Administration (FDA), of those drug products having the same active chemical ingredients.”
(b) “In no case shall a selection be made pursuant to this section if the prescriber personally indicates, either orally or in his or her own handwriting, "Do not substitute," or words of similar meaning. Nothing in this subdivision shall prohibit a prescriber from checking a box on a prescription marked "Do not substitute"; provided that the prescriber personally initials the box or check mark. To indicate that a selection shall not be made pursuant to this section for an electronic data transmission prescription as defined in subdivision (c) of Section 4040, a prescriber may indicate "Do not substitute," or words of similar meaning, in the prescription as transmitted by electronic data, or may check a box marked on the prescription "Do not substitute." In either instance, it shall not be required that the prohibition on substitution be manually initialed by the prescriber.
(c) “Selection pursuant to this section is within the discretion of the pharmacist, except as provided in subdivision (b)…In no case shall the pharmacist select a drug product pursuant to this section unless the drug product selected costs the patient less than the prescribed drug product. Cost, as used in this subdivision, is defined to include any professional fee that may be charged by the pharmacist…”

2) Plan generic policy
The plan requires prior authorization when a brand name drug is being dispensed if a generic equivalent is available on the market. No prior authorization is required if a brand drug is being dispensed as a generic (DAW 5). The plan's established P&T approved criteria, SCFHP Brand Name Prior Authorization Criteria, is used for brand name exception requests when members fail an adequate trial or cannot use a chemically equivalent generic agent.

3) Santa Clara Family Health Plan’s PH.02 Formulary Development and Guideline Management Policy
The plan’s P&T Committee is involved in the development of pertinent pharmacy management processes, including but not limited to cost control measures, therapeutic substitution, and step

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 MCO 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).

   ☒ PA is required.

   ☐ Other, please explain.

Complete **Table 2: Generic Drug Utilization Data** using the following Computation Instructions.

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* ÷ (*S* + *N* + *I*) × 100 = Generic Utilization Percentage**

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

   ***$N* ÷ (*$S* + *$N* + *$I*) × 100 = Generic Expenditure Percentage**

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I, 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. 2020 Excel file).

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

Table 2: Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drug
Total Number of Claims	83,509	1,438,809	83,773
Total Reimbursement Amount Less Co-Pay	82,599,616.00	25,668,560.00	13,580,068.00

3. Indicate the generic utilization percentage for all CODs paid during this reporting period, using the computation instructions in **Table 2: Generic Utilization Drug Data**.

   Number of Generic Claims: 1,438,809

   Total Number of Claims: 1,606,091

   Generic Utilization Percentage: 89.58 %

4. How many multi-source drugs have the innovator as the preferred drug product based on net pricing?

   1,002

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 Utilization Drug Data**.

   Generic Dollars: 25,668,560.00

   Total Dollars: 121,848,244.00

   Generic Expenditure Percentage: 21.07 %

6. Does your MCO have any policies related to Biosimilars? Please explain.

Step Therapy protocols for injectable physician-administered drugs to encourage use of biosimilars

VII. FRAUD, WASTE, AND ABUSE DETECTION (FWA)

A. LOCK-IN OR PATIENT REVIEW AND RESTRICTION PROGRAMS

1. Does your MCO have a documented process in place that identifies potential FWA of controlled drugs by **beneficiaries**?

- (●) Yes
- ( ) No

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

- [ ] Deny claims
- [ ] Require 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)
- [x] Other, please explain.

Identified potential fraud, waste or abuse of controlled drugs by beneficiaries are reviewed by the Director of Pharmacy, or designee, and forwarded to SCFHP's Compliance Department for determination of action.

2. Does your MCO have a Lock-In Program for beneficiaries with potential FWA of controlled substances?

   ○ Yes

   ◉ No

   If "No", skip to question 3.

   If "Yes", please continue.

   a) What criteria does your MCO use to identify candidates for Lock-in? Check **all** that apply:

      ☐ Number of controlled substances (CS)

      ☐ Different prescribers of CS

      ☐ Multiple pharmacies

      ☐ Number days' supply of CS

      ☐ Exclusivity of short acting opioids

      ☐ Multiple ER visits

      ☐ PDMP data

      ☐ Same FFS state criteria is applied

      ☐ Other, please explain.

b) Does your MCO 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/MCO on a case by case basis
- ○ Lock-in time period is based on number of offenses
- ○ Other, please explain.

none

d) On average, what percentage of your Medicaid MCO population is in Lock-in status annually?

_____ %

e) Please provide an estimate of the savings attributed to the Lock-In Program for the fiscal year under review.

_____ %

3. Does your MCO have a documented process in place that identifies potential FWA of controlled drugs by **prescribers**?

◉ Yes

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

☐ Deny claims written by this prescriber

☐ Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation

☐ Refer to the appropriate Medical Board

☒ Other, please explain.

Identified prescribers and claims are reviewed by the Director of Pharmacy, or designee, and forwarded to SCFHP's Compliance Department for determination of action.

○ No, please explain.

4. Does your MCO 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:

☒ Deny claims

☒ Refer to Program Integrity Unit (PIU) and/ or Surveillance Utilization Review (SUR) Unit for audit/investigation

☒ Refer to the Board of Pharmacy

☒ Other, please explain.

The plan delegates pharmacy networks and its oversight to MedImpact. MedImpact's FWA program identifies, audits, and investigates pharmacies based on behavior that suggests potential fraud, waste, and/or abuse activity. The Pharmacy Compliance FWA Team uses consistent processes for the handling of referrals of potential fraud, waste, and abuse. At the conclusion of an FWA analysis, based on the findings, several outcomes are assigned: report, monitor, audit or no action. Actions can include pharmacy terminations from the

○ No, please explain.

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

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

   Identified potential fraud or abuse of non-controlled drugs by beneficiaries are reviewed by the Director of Pharmacy, or designee, and forwarded to SCFHP's Compliance Department for determination of action. The plan has utilization management edits (PA, ST, QL) on selected drugs to prevent potential fraud, waste, or abuse. Additional POS edits includes refill-too-soon, days supply limits, quantity limits, fill limits, plan limits, etc.

   ○ No, please explain.

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

Note: *Section 5042 of the SUPPORT for Patients and Communities Act requires states to report metrics in reference to their state's PDMP. CMS has included questions to reference these metrics to help establish processes to be in compliance with provisions outlined in Section 5042 and CMS reporting, beginning in FFY 2023. Please complete applicable questions below in this section of the survey.*

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

- ○ Yes, receive PDMP data

  Please indicate how often:

  - ○ Daily
  - ○ Weekly
  - ○ Monthly
  - ○ Other, please specify:

- ◉ Yes, have access to the database

  Check **all** that apply:

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

- ○ No, please explain.

If "Yes", please continue.

a) Please explain how your MCO program applies this information to control FWA of controlled substances.

The plan's pharmacists are able to pull beneficiary controlled substance utilization reporting from the California PDMP, Controlled Substance Utilization Review and Evaluation System (CURES) 2.0, in potential FWA cases.

b) Does your MCO have access to Border States' PDMP information?

- ○ Yes
- ◉ No

c) Does your MCO also have PDMP data integrated into your POS edits?

- ○ Yes
- ◉ No

2. Does your MCO or the professional board require prescribers (in your provider agreement) to access the PDMP patient history before prescribing controlled substances?

- ◉ Yes
- ○ No, please explain.

If "Yes", please continue.

a) Are there protocols involved in checking the PDMP?

- ◉ Yes, please explain.

California requires prescribers to consult the Controlled Substance Utilization Review and Evaluation System (CURES) 2.0 database prior to prescribing, ordering, administering, or furnishing a Schedule II-IV controlled substance for the first time and at least once every four months thereafter while the drug remains part of the patient's treatment.

- ○ No

b) Are providers required to have protocols for responses to information from the PDMP that is contradictory to the direction that the practitioner expects from the client?

- ○ Yes
- ◉ No

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

○ Yes

Does your MCO require the provider to submit, upon request, documentation to the MCO?

○ Yes

○ No, please explain.

◉ No, please explain.

The plan does not require prescribers in our provider agreements to access the PDMP patient history before prescribing controlled substances. However, if a prescriber is unable to conduct a PDMP check, California Health and Safety Code 11165.4 requires that the prescriber must document the reason for not consulting the PDMP database in the patient's medical record.

3. Does your MCO require pharmacists to check the PDMP prior to dispending?

○ Yes

Are there protocols involved in checking the PDMP?

○ Yes, please explain.

○ No

◉ No, please explain.

The plan does not require pharmacists to access the PDMP patient history before dispensing controlled substances. However, the plan delegates pharmacy networks and oversight to MedImpact, and pharmacies in MedImpact's pharmacy network follow state requirements. Annually, MedImpact pharmacists are required to attest to being compliant with all state and federal regulations, which can include a requirement to check PDMP prior to dispensing a controlled drug

4. In the State's PDMP system, which of the following pieces of information with respect to a beneficiary, is available to prescribers as close to real-time as possible? Check **all** that apply:

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

Are there barriers that hinder your MCO 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).

Inability to access other states' PDMP information, lag time for prescription data being submitted, unclear directives for health plans' access/use of PDMP data

- ( ) No

5. (Optional) Please specify below the following information for the 12-month reporting period for this survey. Note: Mandatory reporting will be required in FFY2023 under Section 1927(g)(3)(D) of the Act.

   a) The percentage of covered providers who checked the prescription drug history of a beneficiary through a PDMP before prescribing a controlled substance to such an individual:

   _____ %

   b) Average daily MME prescribed for controlled substances per covered individuals who are receiving opioids:

   _____ MMEs

   c) Please complete Tables 3, 4, 5 and 6 below. Specify the controlled substances prescribed based on claim count (by generic ingredient(s)) and within each population during this FFY reporting period.

Table 3: Top Opioid Controlled Substances by Population

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 Substances 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 Substance (Specified in Column 4) in the 12 Month Reporting Period
0-18 yrs.			0.00 %	Top 1 Opioid		0.00 %
				Top 2 Opioid		0.00 %
				Top 3 Opioid		0.00 %
19-29 yrs.			0.00 %	Top 1 Opioid		0.00 %
				Top 2 Opioid		0.00 %
				Top 3 Opioid		0.00 %
30-39 yrs.			0.00 %	Top 1 Opioid		0.00 %
				Top 2 Opioid		0.00 %
				Top 3 Opioid		0.00 %
40-49 yrs.			0.00 %	Top 1 Opioid		0.00 %
				Top 2 Opioid		0.00 %
				Top 3 Opioid		0.00 %
50-59 yrs.			0.00 %	Top 1 Opioid		0.00 %
				Top 2 Opioid		0.00 %
				Top 3 Opioid		0.00 %
60-69 yrs.			0.00 %	Top 1 Opioid		0.00 %
				Top 2 Opioid		0.00 %
				Top 3 Opioid		0.00 %
70-79 yrs.			0.00 %	Top 1 Opioid		0.00 %
				Top 2 Opioid		0.00 %
				Top 3 Opioid		0.00 %
80+ yrs.			0.00 %	Top 1 Opioid		0.00 %
				Top 2 Opioid		0.00 %
				Top 3 Opioid		0.00 %
Individuals with Disabilities Utilizing State Eligibility Categories			0.00 %	Top 1 Opioid		0.00 %
				Top 2 Opioid		0.00 %
				Top 3 Opioid		0.00 %

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.

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.			0.00 %	Top 1 Sedative/Benzodiazepine		0.00 %
				Top 2 Sedative/Benzodiazepine		0.00 %
				Top 3 Sedative/Benzodiazepine		0.00 %
19-29 yrs.			0.00 %	Top 1 Sedative/Benzodiazepine		0.00 %
				Top 2 Sedative/Benzodiazepine		0.00 %
				Top 3 Sedative/Benzodiazepine		0.00 %
30-39 yrs.			0.00 %	Top 1 Sedative/Benzodiazepine		0.00 %
				Top 2 Sedative/Benzodiazepine		0.00 %
				Top 3 Sedative/Benzodiazepine		0.00 %
40-49 yrs.			0.00 %	Top 1 Sedative/Benzodiazepine		0.00 %
				Top 2 Sedative/Benzodiazepine		0.00 %
				Top 3 Sedative/Benzodiazepine		0.00 %
50-59 yrs.			0.00 %	Top 1 Sedative/Benzodiazepine		0.00 %
				Top 2 Sedative/Benzodiazepine		0.00 %
				Top 3 Sedative/Benzodiazepine		0.00 %
60-69 yrs.			0.00 %	Top 1 Sedative/Benzodiazepine		0.00 %
				Top 2 Sedative/Benzodiazepine		0.00 %
				Top 3 Sedative/Benzodiazepine		0.00 %
70-79 yrs.			0.00 %	Top 1 Sedative/Benzodiazepine		0.00 %
				Top 2 Sedative/Benzodiazepine		0.00 %
				Top 3 Sedative/Benzodiazepine		0.00 %
80+ yrs.			0.00 %	Top 1 Sedative/Benzodiazepine		0.00 %
				Top 2 Sedative/Benzodiazepine		0.00 %
				Top 3 Sedative/Benzodiazepine		0.00 %
Individuals with Disabilities Utilizing State Eligibility Categories			0.00 %	Top 1 Sedative/Benzodiazepine		0.00 %
				Top 2 Sedative/Benzodiazepine		0.00 %
				Top 3 Sedative/Benzodiazepine		0.00 %

Table 5: Top Stimulant/ADHD Controlled Substances by Population

When listing the controlled substances in different drug categories, for the purpose of Table 5 below, please consider long and short acting ADHD medications to be in the same category.

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 in the 12 Month Reporting Period	Column 3 Percentage of Unique Beneficiaries Within Each Age Group Receiving a Stimulant/ADHD in the 12 Month Reporting Period	Column 4 Top 3 Stimulant/ADHD 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 (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 (Specified in Column 4) in the 12 Month Reporting Period
0-18 yrs.			0.00%	Top 1 Stimulant/ADHD		0.00%
				Top 2 Stimulant/ADHD		0.00%
				Top 3 Stimulant/ADHD		0.00%
19-29 yrs.			0.00%	Top 1 Stimulant/ADHD		0.00%
				Top 2 Stimulant/ADHD		0.00%
				Top 3 Stimulant/ADHD		0.00%
30-39 yrs.			0.00%	Top 1 Stimulant/ADHD		0.00%
				Top 2 Stimulant/ADHD		0.00%
				Top 3 Stimulant/ADHD		0.00%
40-49 yrs.			0.00%	Top 1 Stimulant/ADHD		0.00%
				Top 2 Stimulant/ADHD		0.00%
				Top 3 Stimulant/ADHD		0.00%
50-59 yrs.			0.00%	Top 1 Stimulant/ADHD		0.00%
				Top 2 Stimulant/ADHD		0.00%
				Top 3 Stimulant/ADHD		0.00%
60-69 yrs.			0.00%	Top 1 Stimulant/ADHD		0.00%
				Top 2 Stimulant/ADHD		0.00%
				Top 3 Stimulant/ADHD		0.00%
70-79 yrs.			0.00%	Top 1 Stimulant/ADHD		0.00%
				Top 2 Stimulant/ADHD		0.00%
				Top 3 Stimulant/ADHD		0.00%
80+ yrs.			0.00%	Top 1 Stimulant/ADHD		0.00%
				Top 2 Stimulant/ADHD		0.00%
				Top 3 Stimulant/ADHD		0.00%
Individuals with Disabilities Utilizing State Eligibility Categories			0.00%	Top 1 Stimulant/ADHD		0.00%
				Top 2 Stimulant/ADHD		0.00%
				Top 3 Stimulant/ADHD		0.00%

Table 6: Populations 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. Please note, Column 2 and Column 4 is requesting an average monthly value based on the 12 month reporting period.

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 per Month Averaged for the 12 Month Reporting Period	Column 3 Percentage of Age Group Receiving 2 or more Controlled Substances Averaged for 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 per Month Averaged for the 12 Month Reporting Period	Column 5 Percentage of Age Group Receiving 3 or more Controlled Substances Averaged for the 12 Month Reporting Period
0-18 yrs.			0.00 %		0.00 %
19-29 yrs.			0.00 %		0.00 %
30-39 yrs.			0.00 %		0.00 %
40-49 yrs.			0.00 %		0.00 %
50-59 yrs.			0.00 %		0.00 %
60-69 yrs.			0.00 %		0.00 %
70-79 yrs.			0.00 %		0.00 %
80+ yrs.			0.00 %		0.00 %
Individuals with Disabilities Utilizing State Eligibility Categories			0.00 %		0.00 %

i) If there is additional information you want to provide for the previous 12-month reporting period, please explain below, or N/A.

N/A

ii) If any of the information requested is not being reported above, please explain below, or N/A.

N/A

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

   ○ 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.

   ◉ No

C. OPIOIDS

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

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

Please explain response above.

Opioids are limited to a maximum 31 day supply.

The plan also has an Opioid-Naive POS safety edit in place. If the POS system identifies the beneficiary as opioid naive (defined as no opioid claims in the past 60 days), the beneficiary will be restricted to no more than two opioid prescriptions within a 30 day period. This POS intervention can be overridden by professional pharmacy services (PPS) codes submitted by

If "No", skip to question 1.b.

a) Is there more than one quantity limit for the various opioids? Additionally, please explain ramifications when addressing COVID-19 if applicable.

- (●) Yes, please explain.

Quantity limits on formulary opioid drugs vary based on FDA label dosing, daily dosing limits, and morphine equivalent daily dosing.

As part of the plan's response to the coronavirus disease 2019 (COVID-19) pandemic, the plan allowed pharmacies to submit emergency claim overrides at POS for prior authorization, step therapy, quantity limit, and refill-too-soon on all drugs, including

- ( ) No

b) What is your maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?

31 # of days

c) Does this days' supply limit apply to **all** opioid prescriptions?

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

Please explain response above.

Initial and subsequent prescriptions are limited to 31 day supply.

The plan also has an Opioid-Naive POS safety edit in place. If the POS system identifies the beneficiary as opioid naive (defined as no opioid claims in the past 60 days), the beneficiary will be restricted to no more than two opioid prescriptions within a 30 day period. This POS intervention can be overridden by professional pharmacy services (PPS

2. For subsequent prescriptions, does your MCO have POS edits in place to limit the quantity dispensed of short-acting (SA) opioids?

- (●) Yes

  What is your maximum days' supply per prescription limitation?

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

    Initial and subsequent prescriptions are limited to 31 day supply.

- ( ) No, please explain.

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

- (●) Yes

  What is your maximum days' supply per prescription limitation?

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

    Initial and subsequent prescriptions are limited to 31 day supply.

- ( ) No, please explain.

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

◉ Yes, please check **all** that apply:

- ☐ Pharmacist override
- ☒ Deny claim and require PA
- ☐ Intervention letters
- ☐ MME daily dose program
- ☒ 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
- ☐ Require documentation of urine drug screening results
- ☐ Require diagnosis
- ☐ Require PDMP checks
- ☐ Workgroups to address opioids
- ☒ Other, please specify.

SCFHPs Quantity Limit Prior Authorization criteria requires that if cumulative opioid dosage is greater than or equal to 90 MEDD, history of a naloxone prescription within the last 2 years is required.

Please provide details on these opioid prescribing controls are in place.

In addition to quantity limits and days supply limits on opioids, the plan has the following additional measures in place to prevent opioid overutilization:

- 'Deny claim and require PA' - The dispensing pharmacist cannot override at POS. The plan requires PA to review opioid requests appropriately against P&T Committee approved coverage criteria.

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

5. Does your MCO 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 above response.

   ProDUR therapeutic duplication edit sends alert messages to the pharmacist for concurrently prescribed opioids when there is an overlap in days supply.

6. Does your MCO have POS edits and an automated retrospective claims review process to monitor early refills of opioid prescriptions dispensed?

- (●) Yes, POS edits
- ( ) Yes, automated retrospective claims review process
- ( ) Yes, both POS edits and automated retrospective claims review process
- ( ) No

If any response is "Yes", please explain scope and nature of reviews and edits.

The plan employs a point-of-sale refill-too-soon edit that denies opioid prescriptions when refilled early.

If "No", please explain.

7. Does your MCO have a comprehensive automated retrospective claims review process to monitor opioid prescriptions exceeding state limitations?

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

The plan has the following processes in place:
1. POS refill-too-soon edits for opioids
2. POS Opioid Cumulative Dosing Soft Edit and Opioid Cumulative Dosing Hard Edit - When prior authorization (PA) requests are received due to these POS rejections, the PA is reviewed for medical necessity of the requested exceeding quantity. Approved prior authorizations expire after 12 months, so this enables review of ongoing treatment with higher opioid doses

- ( ) No, please explain.

8. Does your MCO currently have POS edits in place or an automated retrospective claims review process to monitor opioids and benzodiazepines being used concurrently?

- ○ Yes, POS edits
- ○ Yes, automated retrospective claims review process
- ◉ Yes, both POS edits and automated retrospective claims review process

Please explain the above response and detail the scope and nature of these reviews and/or 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).

The plan has a POS safety edit called Opioid-Benzodiazepine Concurrent Use. This POS intervention will deny an incoming claim when there is any overlap in day supply of a benzodiazepine and an opioid, and the prescriptions are from two or more prescribers from different offices. This intervention is bidirectional and will stop either a claim for a benzodiazepine or an opioid if the beneficiary is currently on the other. This intervention can be overridden by PPS codes submitted by the dispensing pharmacist or through the PA process.

- ○ No, please explain.

9. Does your MCO currently have POS edits in place or an automated retrospective claims review process to monitor opioids and sedatives being used concurrently?

- ○ Yes, POS edits
- ○ Yes, automated retrospective claims review process
- ◉ Yes, both POS edits and automated retrospective claims review process

Please explain the above response and detail the scope and nature of these reviews and/or edits.

The plan employs POS edits and retrospective reviews for opioids-sedatives used concurrently. A ProDUR drug-drug interaction edit alerts pharmacists of safety issues with concomitant use of opioids with sedatives. Retrospective reviews of concurrent opioid-sedatives use can be filtered to identify prescriber, member and pharmacy.

- ○ No, please explain.

10. Does your MCO currently have POS edits in place or an automated retrospective claims review process to monitor opioids and antipsychotics being used concurrently?

- ○ Yes, POS edits
- ○ Yes, automated retrospective claims review process
- ◉ Yes, both POS edits and automated retrospective claims review process

Please explain the above response and detail the scope and nature of these reviews and/or edits.

Antipsychotic carve out claims data is loaded into the PBM's claims system. The plan has a POS safety edit called Opioid-Antipsychotic Concurrent Use. This POS intervention will deny an incoming claim when there is any overlap in day supply of an antipsychotic and an opioid, and the prescriptions are from two or more prescribers from different offices. This intervention is unidirectional and will only deny the incoming opioid claim if the beneficiary is currently on an antipsychotic. This intervention can be overridden by PPS codes submitted by the dispensing

- ○ No, please explain.

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

- ○ Yes, POS edits
- ○ Yes, automated retrospective claims review and/or provider education
- ○ Yes, both POS edits and automated retrospective claims review and/or provider education
- ◉ No

If "No", skip to question 11.c.

If "Yes, automated retrospective claims review and/or provider education", please continue with questions 11.a and 11.b.

a) Please indicate how often:

- ○ Monthly
- ○ Quarterly
- ○ Semi-Annually
- ○ Annually
- ○ Ad hoc
- ○ Other, please specify.

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

If "No", please continue.

c) Does your MCO plan on implementing automated retrospective claims review and/or provider education in regard to beneficiaries with a diagnosis or history of OUD or opioid poisoning in the future?

◉ Yes, when does your MCO plan on implementing?

The plan is actively working on creating a provider education program in regards to beneficiaries with a diagnosis or history of OUD or opioid poisoning and plans to implement by end of June 2021.

○ No, please explain.

12. Does your MCO program develop and provide prescribers with pain management or opioid prescribing guidelines?

◉ Yes, please check **all** that apply:

☒ Your prescribers are referred to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain

☐ Other guidelines, please identify.

○ No, please explain why no guidelines are offered.

13. Does your MCO 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.
- ◉ No

D. **MORPHINE MILLIGRAM EQUIVALENT (MME) DAILY DOSE**

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

- (●) Yes
- ( ) No, please explain the measure or program you utilize.

If "Yes", please continue.

a) What is your maximum MME daily dose limit in milligrams?

- ( ) Less than 50 MME

  Please specify. _____ mg per day
- ( ) 50 MME
- ( ) 70 MME
- ( ) 80 MME
- ( ) 90 MME
- ( ) 100 MME
- ( ) 120 MME
- (●) 200 MME
- ( ) Greater than 200 MME

  Please specify. _____ mg per day

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

Morphine milligram equivalent (MME) soft and hard point-of-sale (POS) safety edits are based on CDC guidelines. The limit applies to all opioids with a CDC MME conversion factor. The POS edits use a drug list that includes short acting and long acting opioids. The edits apply to all beneficiaries regardless of opioid history and allows tapering. The edits do not apply to beneficiaries being treated for active cancer-related pain or sickle cell disease, beneficiaries receiving palliative/end-of-life care, beneficiaries who are residents

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

- (●) Yes
- ( ) No

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

- (●) Yes
- ( ) No

3. Does your MCO have automated retrospective claims review to monitor the MME total daily dose of opioid prescriptions dispensed?

- (●) Yes, please explain.

The plan utilizes MedImpact automated edits and retrospective reporting to monitor cumulative MME.

- ( ) No, please explain.

4. Does your MCO provide information to your prescribers on how to calculate the morphine equivalent daily dosage or does your MCO 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.

      CDC, Washington State Agency Medical Directors' Group, and Oregon Health Authority

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

      ☐ Website

      ☒ Provider notice

      ☐ Educational seminar

      ☐ Other, please explain.

E. OPIOID USE DISORDER (OUD) TREATMENT

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

   ○ Yes, please explain.

   ○ No

2. Does your MCO 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.

Buprenorphine, buprenorphine/naloxone combinations, naloxone, and naltrexone for OUD are carved out to FFS agency. The plan does not have a limit for methadone length of treatment.

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

- ○ Yes
- ◉ No

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

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

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

- ○ Yes
- ○ No

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

   ○ Yes

   ◉ No

8. Does your MCO have at least one naloxone opioid overdose product available without PA?

   ○ Yes

   ◉ No

9. Does your MCO retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?

   ○ Yes

   ◉ No, please explain.

   SCFHPs Quantity Limit Prior Authorization criteria requires that if cumulative opioid dosage is greater than or equal to 90 MEDD, history of a naloxone prescription within the last 2 years is required.

10. Does your MCO allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, or standing orders, or other predetermined protocols?

    ◉ Yes, please explain.

    SCFHP allows pharmacists to dispense naloxone prescribed independently in accordance with 16 CCR § 1746.3

    ○ No

F. OUTPATIENT TREATMENT PROGRAMS (OTP)

1. Does your MCO cover OTPs that provide behavioral health (BH) and MAT through OTPs?

   ○ Yes

   ◉ No, please explain.

   OTPs that provide behavioral health and medication-assisted treatment, including substance use treatment services, are carved out to Santa Clara County Behavioral Health Department. The referral process involves directing beneficiaries to the county call center for a screening and entrance into system services.

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

   ○ Yes, please explain.

   ○ No, please explain.

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

   ○ Yes

   ◉ No, please explain.

   Buprenorphine and buprenorphine/naloxone combinations are carved out to FFS agency.

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

   ○ Yes

   ◉ No, please explain.

   Naltrexone is carved out to FFS agency.

4. Does your MCO cover Methadone for substance use disorder (i.e. OTPs, Methadone Clinics)?

   ◉ Yes

   ○ No

G. **ANTIPSYCHOTICS /STIMULANTS**

ANTIPSYCHOTICS

1. Does your MCO currently have restrictions in place to limit the quantity of antipsychotics?

   ○ Yes

   ◉ No

   Please explain restrictions or N/A.

   Antipsychotics are carved out to FFS agency.

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

- ○ Yes
- ◉ No

If "No", skip to question 2.d.

If "Yes", please continue with questions 2.a, 2.b and 2.c.

a) Does your MCO either manage or monitor:

- ○ Only children in foster care
- ○ **All** children
- ○ Other, please explain.

b) Does your MCO 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 antipsychotic monitoring program(s).

If "No," please continue.

d) Does your MCO plan on implementing a program in the future?

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

  The plan is actively working on creating a program to monitor the appropriate use of antipsychotic drugs in children and plans to implement by end of June 2021.

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

STIMULANTS

3. Does your MCO currently have restrictions in place to limit the quantity of stimulants?

   - (●) Yes
   - ( ) No

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

   - (●) Yes
   - ( ) No

   If "No", skip to question 4.d.

   If "Yes", please continue with questions 4.a, 4.b and 4.c.

   a) Does your MCO either manage or monitor:

      - ( ) Only children in foster care
      - ( ) **All** children
      - (●) Other, please explain.

      The plan monitors stimulant drugs regardless of age. The plan reviews and monitors pharmacy claims utilization quarterly that includes stimulant drugs.

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

      - [ ] Child's Age
      - [x] Dosage
      - [ ] Indication
      - [ ] Polypharmacy
      - [ ] Other, please explain.

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

Most stimulants have quantity limits based on FDA label dosing and dosing limits.

If "No", please continue.

d) Does your MCO plan on implementing a 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.

VIII. INNOVATIVE PRACTICES

1. Does your MCO 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 4: Innovative Practices**

   Have you developed any innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MMEs, 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 federal fiscal year 2020, Santa Clara Family Health Plan completed the following initiatives to promote appropriate and effective medication use to improve patient safety:

1. Prepared for the transition of pharmacy benefits to Medi-Cal Fee-for-Service (called Medi-Cal Rx), including:
- Identified members not using pharmacies in the Medi-Cal Rx network to offer assistance via mail outreach to ensure appropriate continuity of care for their prescriptions
- Identified a mail order pharmacy in the Medi-Cal Rx network, but not in the plan's network, and initiated contracting with that pharmacy to improve mail order access and ease transition into Medi-Cal Rx benefits

2. Streamlined ordering blood pressure monitors by developing a durable medical equipment (DME) order form and partnering with a network DME provider

3. Targeted pharmacist outreach to Vietnamese speaking members with poor medication adherence to asthma maintenance medications (based on claims data) to provide consultations and assistance

4. Implemented pharmacy-related COVID-19 policy and procedures, including:
- Allowed pharmacies to submit emergency claim overrides at POS for prior authorization, step therapy, quantity limit, and refill-too-soon on all drugs
- Modified prior authorization criteria to allow for longer approval durations
- Added gloves and select disinfectants to formulary

5. In response to the COVID-19 pandemic, promoted the mail order benefit and coverage of 90-day supply prescriptions in the member newsletter

IX. EXECUTIVE SUMMARY

Summary 5: Executive Summary

Please include a general overview and summary of program highlights from FFY 2020 as well as objectives, tools and outcomes of initiatives accomplished, and goals for FFY 2020. Include a summary of program oversight and initiatives.

In compliance with All Plan Letter 17-008, Santa Clara Family Health Plan (SCFHP) has a drug utilization review (DUR) program that includes a prospective DUR process, a retrospective DUR process, educational outreach to providers, and participation in the Medi-Cal State DUR Board.

SCFHP's pharmacy benefit manager, MedImpact, is delegated to implement point-of-sale (POS) edits and alerts to screen for potential drug therapy problems prior to dispensing. SCFHP reviews the list of drugs and POS rejections quarterly and proposes formulary utilization management edits using compendia and peer-reviewed medical literature, if applicable.

Through ongoing review of claims data and other records, SCFHP conducts drug use evaluation (DUE) programs that identify opportunities in drug usage and patterns and provide related education to providers via mailed letters. SCFHP revisits the completed DUE program one year later to measure the program's efficacy. The following DUE programs were conducted: Statin Use in Persons with Diabetes, Coronary Artery Disease, and Congestive Heart Failure. General provider DUR education is provided by publishing articles in SCFHP's provider newsletter and through faxed provider memos. Educational outreach to pharmacists in SCFHP's pharmacy network is completed through quarterly newsletters and fax communications from MedImpact. To identify potential fraud, waste, and abuse (FWA) by members, providers, and pharmacies, MedImpact provides SCFHP with monthly newsletters and quarterly reports. The Director of Pharmacy or designee reviews FWA reports and forwards any findings to SCFHP's Compliance Department for determination of action.

SCFHP uses the FFS Agency (Medi-Cal State) DUR Board and its educational components. However, SCFHP maintains its current proprietary claims processing procedures and protocols and administers the systematic components related to the prospective and retrospective DUR processes. SCFHP sends one representative to attend Medi-Cal State DUR Board meetings in-person, and this representative makes recommendations on which DUR actions and/or activities the plan should adopt. All DUR reporting and DUR-related decisions are shared with and approved by SCFHP's Pharmacy and Therapeutics (P&T) Committee quarterly.

During FFY 2020, SCFHP responded to the COVID-19 pandemic by allowing emergency point-of-sale overrides at the pharmacy, adjusting refill thresholds, extending prior authorization criteria approval durations, and adding gloves and select disinfectants to formulary to remove potential barriers to drug access during a global public health emergency.

APPENDIX A: MCO PROGRAM TYPES

DEFINITIONS OF MANAGED CARE PROGRAM TYPES

A managed care program is defined by the set of benefits covered and the type of participating managed care plans (e.g., MCOs, PHPs, PACE, etc.) or providers (e.g., PCCM providers).

Managed Care Program Type	Definition
Comprehensive MCO	Comprehensive Managed Care Organization: A program in which the State contracts with managed care plans to cover all acute and primary medical services; some also cover behavioral health, dental, transportation and long term care. Entities that qualify as MCOs include Health Maintenance Organizations (HMOs) and Health Insuring Organizations (HIOs in California). If the comprehensive MCO also covers long-term services and supports, the program type should be Comprehensive MCO + MLTSS. When certain benefits, such as behavioral health, dental, or transportation, are carved out of the comprehensive MCO program and covered through a limited benefit program (i.e. a Prepaid Inpatient Health Plan or Prepaid Ambulatory Health Plan), enrollees in such limited benefit plans should be reported in separate programs of the appropriate type (e.g., BHO (PIHP and/or PAHP), Dental PAHP, or Non-Emergency Medical Transportation, or an MLTSS-only program when only LTSS and no other services are covered. Individual beneficiaries can be enrolled in only one comprehensive MCO program (either a comprehensive MCO or a comprehensive MCO+MLTSS) as of the July 1 point in time.
Comprehensive MCO + MLTSS	Comprehensive Managed Care Organization + Managed Long-Term Services and Supports: A program in which plans cover comprehensive acute and outpatient benefits as defined above, where the same plan also covers long- term services and supports (LTSS). Individual beneficiaries can be enrolled in only one comprehensive MCO program (either a comprehensive MCO or a comprehensive MCO+MLTSS).
BHO Only (PIHP and/or PAHP)	Behavior Health Organizations Only (Prepaid Inpatient Health Plan and/or Prepaid Ambulatory Health Plan): A program specializing in behavioral health (mental health and/or substance use disorder) services. Services are covered on a prepaid basis.
Dental only (PAHP)	A Prepaid Ambulatory Health Program (PAHP) that only provides dental services.
MLTSS Only	Managed Long Term Services and Supports Only: A program only covering long term services and supports.
Other PHP	Other Prepaid Health Plan: A program covering a limited set of services through PIHPs or PAHPs not otherwise included above. Examples include disease management and pharmacy benefits.

Managed Care Program Type	Definition
PACE	Programs of All-Inclusive Care for the Elderly: A program that provides prepaid, capitated comprehensive medical and social services in an adult day health center, supplemented by in-home and referral services according to a participant's needs. To qualify, individuals must: (1) be 55 years of age or older, (2) meet a nursing home level of care, and (3) live in a PACE organization service area.
PCCM	Primary Care Case Management: A managed care arrangement in which primary care providers contract with the state to provide a core set of case management services to the enrollees assigned to them and to serve as the enrollees' home for medical care, in exchange for a monthly case management fee. All other services are reimbursed on a FFS basis. Primary Care Providers (PCPs) can include primary care physicians, clinics, group practices and nurse practitioners, among others. In general, we would only expect case management and physician services to be covered under capitation for PCCM programs.
PCCM entity	Primary Care Case Management entity: In addition to providing primary care case management services for the State, a PCCM entity is an organization that provides any of the following functions: (1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line; (2) Development of enrollee care plans; (3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program; (4) Provision of payments to FFS providers on behalf of the State; (5) Provision of enrollee outreach and education activities; (6) Operation of a customer service call center; (7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement; (8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; (9) Coordination with behavioral health systems/providers; and/or (10) Coordination with long-term services and supports systems/ providers.
Non-Emergency Medical Transportation (NEMT)	A program that covers transportation to and from medically necessary health care services in which these services are paid for on a per capita basis (the state pays the transportation broker based on the number of people served, not the amount of service or trips that each individual receives). Do not report transportation programs in which individual trips are reimbursed on a FFS basis.

MANAGED CARE PLAN CROSSWALK

The table below provides a crosswalk for plan types to program types.

Managed Care Plan Type	Managed Care Program Type
Comprehensive MCO	• Comprehensive MCO • Comprehensive MCO +MLTSS (if benefits include LTSS)
Traditional PCCM Provider	• PCCM
Enhanced PCCM Provider	• PCCM
HIO	• Comprehensive MCO
Medical-only PIHP (risk or non-risk/non-comprehensive/with inpatient hospital or institutional services)	• Other PHP
Medical-only PAHP (risk or non-risk/non-comprehensive/no inpatient hospital or institutional services)	• Other PHP
Long Term Care (LTC) PIHP	• MLTSS Only
Mental Health (MH) PIHP	• BHO (PIHP and/or PAHP)
Mental Health (MH) PAHP	• BHO (PIHP and/or PAHP)
Substance Use Disorders (SUD) PIHP	• BHO (PIHP and/or PAHP)
Substance Use Disorders (SUD) PAHP	• BHO (PIHP and/or PAHP)
Mental Health (MH) and Substance Use Disorders (SUD) PIHP	• BHO (PIHP and/or PAHP)
Mental Health (MH) and Substance Use Disorders (SUD) PAHP	• BHO (PIHP and/or PAHP)
Dental PAHP	• Dental
Transportation PAHP	• NEMT
Disease Management PAHP	• Other PHP
PACE	• PACE
Pharmacy PAHP	• Other PHP
Accountable Care Organization	• Comprehensive MCO • Other PHP • PCCM
Health/Medical Home	• PCCM

Managed Care Plan Type	Managed Care Program Type
Integrated Care For Dual Eligibles	• Comprehensive MCO + MLTSS, • MLTSS Only (if benefits cover LTSS)
Unknown – it is not yet known how PCCM entities will be reported in T-MSIS.	• PCCM entity

APPENDIX B: DRUG NAMES

0.9 % sodium chloride
abacavir
abacavir/dolutegravir/lamivudine
abacavir/lamivudine
abacavir/lamivudine/zidovudine
abatacept
acetaminophen
acetaminophen with codeine
acyclovir
adalimumab
adapalene
adapalene/benzoyl peroxide
aflibercept
albuterol
alglucosidase alfa
alogliptin
alogliptin/metformin
alogliptin/pioglitazone
alprazolam
ambrisentan
amlodipine
amlodipine/atorvastatin
amlodipine/benazepril
amlodipine/olmesartan
amlodipine/valsartan
amoxicillin
amoxicillin/potassium clavulanate
amphetamine
apixaban
apremilast
aripiprazole
armodafinil
asenapine
aspirin
atezolizumab
atomoxetine
atorvastatin
azithromycin
aztreonam
bacitracin
bacitracin/polymyxin B
baclofen
beclomethasone
belimumab
benzonatate
benztropine
bevacizumab
bictegravir/emtricitabine/tenofovir
brexpiprazole
brompheniramine
brompheniramine/phenylpropanolamine
brompheniramine/pseudoephedrine
brompheniramine/pseudoephedrine/dextromethorphan
budesonide
budesonide/formoterol
buprenorphine
buprenorphine/naloxone
bupropion
buspirone
cabergoline
calcipotriene
calcipotriene/betamethasone
calcitriol
cannabidiol (CBD)
capsaicin
carbetapentane/ephed/phenylephrine/chlorphenir
cariprazine
carisoprodol
carisoprodol/aspirin
carisoprodol/aspirin/codeine
carvedilol

cefdinir
ceftriaxone
celecoxib
cephalexin
certolizumab
cetirizine
chlorhexidine
chlorpromazine
cinacalcet
ciprofloxacin/dexamethasone
citalopram
clarithromycin
clindamycin
clindamycin/benzoyl peroxide
clindamycin/tretinoin
clobazam
clobetasol
clonazepam
clonidine
clopidogrel
coagulation factor VIIa (recombinant)
colchicine
corticotropin
crisaborole
cyclobenzaprine
cyclosporine
cyproheptadine
daptomycin
daratumumab
darunavir
darunavir ethanolate
darunavir ethanolate/cobicistat
dasatinib
deferasirox
desvenlafaxine
dexamethasone
dexbrompheniramine/phenylephrine
dexmethylphenidate
dextroamphetamine
dextroamphetamine/amphetamine
dextromethorphan
dextrose
diazepam
diclofenac
dimethyl fumarate
diphenhydramine
divalproex
docusate
dolutegravir
dornase alfa
doxercalciferol
doxycycline
doxylamine
doxylamine/phenylephrine
doxylamine/pyridoxine
dronabinol
dulaglutide
duloxetine
dupilumab
eculizumab
efavirenz/emtricitabine/tenofovir
elexacaftor/tezacaftor/ivacaftor
elvitegravir/cobicistat/emtricitabine/tenofovir
emicizumab
empagliflozin
emtricitabine
emtricitabine/rilpivirine/tenofovir
emtricitabine/tenofovir
enoxaparin
epinephrine
epoetin alfa
erenumab
ergocalciferol
escitalopram
esomeprazole

etanercept
eteplirsen
etonogestrel
everolimus
exenatide
ezetimibe
ezetimibe/simvastatin
famotidine
fentanyl
fexofenadine
fexofenadine/pseudoephedrine
fingolimod
fluconazole
fludeoxyglucose
fluocinolone
fluoride
fluoride/iron/vitamins A,C,and D
fluoride/vitamins A,C,and D
fluoxetine
fluticasone
fluticasone/salmeterol
fluticasone/vilanterol
folic acid
folic acid/vitamin B complex and vitamin C
gabapentin
galcanezumab
glatiramer
glecaprevir/pibrentasvir
glipizide
glucagon
glycerol phenylbutyrate
glycopyrrolate
guaifenesin
guaifenesin/hydrocodone
guaifenesin/phenylephrine
guanfacine
guselkumab
haloperidol
heparin
hyaluronate
hydrochlorothiazide
hydrocodone
hydrocodone/acetaminophen
hydrocodone/chlorpheniramine
hydrocodone/homatropine
hydrocodone/ibuprofen
hydrocortisone/lidocaine/aloe vera
hydromorphone
hydroxyprogesterone
hydroxyzine
ibuprofen
ibuprofen/oxycodone
icatibant
imatinib
immune globulin,gamm(IgG)/glycine/IgA greater than 50 mcg/mL
immune globulin,gamma(IgG)/glycine/IgA average 46 mcg/mL
infliximab
insulin aspart
insulin degludec
insulin detemir
insulin glargine
insulin lispro
interferon gamma-1b,recomb.
ipratropium
ipratropium/albuterol
isotretinoin
ivacaftor
ivermectin
ixekizumab
ketoconazole
ketorolac
lacosamide
lamotrigine
lansoprazole

ledipasvir/sofosbuvir
lenalidomide
leuprolide
levalbuterol
levetiracetam
levocetirizine
levonorgestrel
levothyroxine
lidocaine
lidocaine/aloe vera
lidocaine/epinephrine
lidocaine/hydrocortisone
lidocaine/prilocaine
lifitegrast
linagliptin
linezolid
lipase/protease/amylase
liraglutide
lisdexamfetamine
lisinopril
lithium
lopinavir/ritonavir
loratadine
lorazepam
losartan
lumacaftor/ivacaftor
lurasidone
macitentan
medroxyprogesterone
megestrol
meloxicam
mercaptopurine
mesalamine
metformin
methadone
methamphetamine
methotrexate
methylphenidate
methylprednisolone
methyltestosterone
metoprolol
metronidazole
mirtazapine
modafinil
mometasone
mometasone/formoterol
montelukast
morphine
multivitamin
multivitamin with iron
multivitamins with Fluoride
multivitamins with Iron & Fluoride
mupirocin
mycophenolate
naloxone
naproxen
natalizumab
neomycin/bacitracin/polymyxin B/lidocaine
neomycin/polymyxin B/lidocaine
nicotine
nilotinib
nitrofurantoin
nivolumab
norelgestromin/ethinyl estradiol
norepinephrine
norgestimate-ethinyl estradiol
nusinersen
nystatin
nystatin/triamcinolone
ocrelizumab
olanzapine
olanzapine/fluoxetine
olopatadine
omalizumab
omeprazole
onabotulinumtoxinA

ondansetron
oseltamivir
osimertinib
oxcarbazepine
oxycodone
oxycodone/acetaminophen
oxycodone/aspirin
oxycodone/oxycodone terephthalate/aspirin
oxymorphone
palbociclib
paliperidone
palivizumab
pantoprazole
pediatric multivitamin
pegfilgrastim
pembrolizumab
penicillin G potassium
penicillin G procaine
penicillin G sodium
penicillin V potassium
pentazocine/naloxone
permethrin
pertuzumab
phentermine
phenylephrine
phenylephrine/hydrocodone/chlorpheniramine
phenylephrine/promethazine
phenylephrine/pyrilamine
phenylpropanolamine/hydrocodone
polyethylene glycol 3350
posaconazole
prazosin
prednisolone
prednisone
pregabalin
probenecid/colchicine
propofol
pyridoxine
quetiapine
racepinephrine
ranibizumab
ranitidine
ranolazine
rifaximin
risperidone
ritonavir
rituximab
rivaroxaban
rizatriptan
ropinirole
rosuvastatin
rufinamide
sacubitril/valsartan
secukinumab
semaglutide
sertraline
sevelamer
sildenafil
simvastatin
sitagliptin
sitagliptin/metformin
sodium fluoride/potassium nitrate
sodium oxybate
sofosbuvir/velpatasvir
somatropin
spinosad
sucralfate
sulfamethoxazole/trimethoprim
sumatriptan
sumatriptan succinate/naproxen sodium
tacrolimus
tamsulosin
teduglutide
telmisartan/amlodipine
tenofovir
teriflunomide

testosterone
tetrabenazine
tezacaftor/ivacaftor
ticagrelor
tiotropium
tizanidine
tobramycin
tobramycin/dexamethasone
tobramycin/nebulizer
tofacitinib
topiramate
tramadol
trastuzumab
trazodone
treprostinil
tretinoin
triamcinolone
triprolidine
triprolidine/pseudoephedrine
umeclidinium
ustekinumab
valacyclovir
valbenazine
valganciclovir
valsartan
valsartan/hydrochlorothiazide
vancomycin
varenicline
vedolizumab
venlafaxine
vigabatrin
vortioxetine
warfarin
zaleplon
ziprasidone
zolpidem
other

APPENDIX C: DRUG CLASSES

acne agents
alzheimer agents
analgesics, narcotic agents
androgenic agents
anesthetics agents
angiotensin modulator agents
angiotensin modulator/calcium channel blocker combination agents
antibiotics, gi agents
antibiotics, inhaled agents
antibiotics, otic agents
antibiotics, topical agents
antibiotics, vaginal agents
anticoagulant agents
anticonvulsant agents
antidepressant agents
antiemetic agents
antifungal agents
antihemophilic factor ix agents
antihemophilic factor viii/vwf agents
antihistamine agents
antihypertensives, sympatholytic agents
antihyperuricemic agents
antimigraine agents
antiparasitic agents
antiparkinson's agents
antipsoriatic agents
antipsychotic agents
antiviral agents
antivirals, antiretroviral agents
antivirals, hepatitis c agents
antivirals, other agents
anxiolytic agents
attention deficit hyperactivity disorder agents
benign prostatic hyperplasia agents
beta blocker agents
bile salt agents
bladder relaxant agents
bone resorption suppression and related agents
bronchodilator agents
calcium channel blocker agents
cephalosporin agents
chronic obstructive pulmonary disease agents
colony stimulating factor agents
constipation agents
contraceptive agents
cough and cold agents
cytokine and cam antagonist agents
diabetic testing blood glucose meters, test strips, lancets
diuretic agents
epineprine agents
erythropoiesis stimulating protein agents
fluoroquinolone agents
glucocorticoid agents
growth hormone agents
hereditary angioedema agents
histamine ii receptor blocker agents
hypoglycemic agents
immunomodulators
intranasal rhinitis agents
leukotriene receptor antagonist agents
lincosamides/oxazolidinones/streptogramin agents
lipotropic agents
macrolide agents
mood stabilizer agents
movement disorder agents
multiple sclerosis agents
neuropathic pain agents
nsaid agents
oncology agents
ophthalmic agents

opiate dependence agents
opiate overdose agents
pancreatic enzyme agents
penicillin agents
phosphate binder agents
pituitary suppressants, central precocious puberty (cpp) agents
platelet aggregation inhibitor agents
progestational agents
proton pump inhibitor agents
pulmonary arterial hypertensive agents
sedative hypnotic agents
skeletal muscle relaxant agents
steroid agents
stimulants and related agents
tetracycline agents
thyroid hormone agents
ulcerative colitis agents
urinary anti-infective agents
vasodilator agents
vitamin agents
other

APPENDIX D: DENIAL CODES

accumulation refill too soon
age
bill Medicare
brand request
claim requires an approved treatment authorization request (tar)
claim submitted does not match pa
compliance monitoring/early or late refill
cumulative early refill
daily dose exceeded
days supply
drug covered by Medicare part D
drug list initiative threshold
drug-disease reported precaution
drug-drug interaction
duplicate claim
DUR reject error
early refill: overuse precaution
eligibility
exceeds allowable plan days supply
filled after coverage terminated
high dose alert
M/I days supply
M/I diagnosis code
M/I other coverage code
M/I prescriber
MD must call for a prior authorization
member enrolled in managed care
members benefits package does not include this medication
NDC not consistent with any billed diagnosis
NDC not covered
NDC vs diagnosis restriction
no rebate
non-covered and non-rebate products
non-matched prescriber ID
non-preferred drug
over utilization precaution

patient is not covered
PDL
pharmacy maintenance supply required for drug
plan limitations exceeded
prescriber is not covered
prior authorization required
product not on formulary
product/service not covered - plan/benefit exclusion
produr alert
provider not enrolled in benefit plan
quantity dispensed exceeds maximum allowed
refill exceeds max. allowable refills
refill too soon
reported disease
service not covered
submit bill to other processor or primary payor
tamper proof pad reqd
therapeutic duplication
under utilization precaution
other

Emergency Prescription Access Report
2nd Quarter 2020
Santa Clara Family Health Plan

Analysis Goal: Evaluate access to medications prescribed pursuant to an emergency room (ER) visit and determine whether any barriers to care exist.

Methodology: Claims and encounter records for an emergency room visit during a calendar quarter will be evaluated and analyzed by network, primary diagnosis, and claims status. Prescription claims history will be evaluated to assess if any prescriptions were filled by the member within 72 hours of the ER visit date. Key diagnosis used will be urinary tract infection (UTI) due to clinical determination that such a diagnosis will require a prescription, particularly for antibiotic. Analysis includes: 1. Approved antibiotic claims: sampling of cases to evaluate for sufficient quantity based on diagnosis and medication per nationally recognized drug compendia and the Infectious Disease Society of America (IDSA) guidelines; 2. Denied antibiotic claims: sampling of cases to evaluate sufficient quantity based on diagnosis and medication as well as denial reasons; 3. No claims history: sampling of cases through claims history review as well as chart review of no related prescription claims history following an emergency room visit to identify non-pharmacy point-of-sale in-hospital dispensing or completion of in-house antibiotics regimen.

Summary of Findings:

Section 1 – ER Visits

In Q2 2020, SCFHP had total 12,865 ER visits from claims and encounter data.

Table 1: Members by Provider Network

Network	Unique Members	ER Visit Rx	ER Visit w/o Rx	Total ER Visits
No Network	652	181	724	905
Non-Delegated	883	728	608	1,336
Valley Health Plan	5,690	3,945	4,310	8,255
Palo Alto Medical Foundation	177	112	136	248
Physician Medical Group	1,372	878	907	1,785
Premier Care	272	187	149	336
Grand Total	9,046	6,031	6,834	12,865

Section 2 – Diagnosis

Table 2: Key Diagnosis

		2Q2020		
Code	Diagnosis	Rx	No Rx	% Rx
N390	UTI, SITE NOT SPEC	162	55	74.7%

Section 3 – Claims Analysis

Approved Claims

Treatment guidelines for urinary tract infection/uncomplicated cystitis treatment are typically for at least 3 days, with the exception of fluconazole, fosfomycin, and ofloxacin that are administered as a single dose. Of prescriptions processed, we evaluated quantity per day supply and total day supply. There were no prescriptions filled inappropriately for less than a quantity of 1 per day. In this section we will focus on approved prescriptions with 2 day supply or less to evaluate if sufficient quantity and day supplies were written.

Table 3: Approved Antibiotics Prescribed for UTI 2-Day Supply or Less

DRUG	Day Supply	Svc Prov Name	Approved
FLUCONAZOLE	**1**	Regional Medical Center of SJ	**1**
MORUNOL	**1**	El Camino Hospital – Mountain View	**1**
Grand Total			**2**

We did not identify any issues with approved claims. Fluconazole and Morunol were appropriately written for a 1 day supply for 2 prescriptions.

Denied Claims

We excluded those members who had primary insurance coverage outside of SCFHP. There were no inappropriate denied claims.

No Claims

55 unique members diagnosed with UTI ER claims did not result in a prescription processed within 72 hours. We initially excluded 22 members with primary insurance coverage outside of SCFHP from this analysis. We subsequently randomly chose a sample of approximately 20% of 33 members, which is 8 total members, using Excel. We requested 6 chart notes from different hospitals. We received and reviewed 6 appropriate charts. Findings are presented below.

Mbr	Hospital	DOS	Findings
1	Regional Medical Center of SJ	06/23/2020	Nitrofurantoin 100mg cap filled for #14/7 days on 6/30/2020
2	Regional Medical Center of SJ	05/18/2020	Cephalexin 500mg cap filled #28/7 days on 5/2/2020, Nitrofurantoin 100mg cap #28/14 days on 5/18/2020
3	Regional Medical Center of SJ	06/27/2020	Chart note reviewed. Ceftriaxone 1gram x1 ER. Rx for ciprofloxacin 500mg #20/10 days, not filled.
4	Regional Medical Center of SJ	06/08/2020	Chart note reviewed. Cephalexin 500mg cap x1 ER. Rx given, not filled.
5	Santa Clara Valley Medical Center	04/16/2020	Chart note reviewed. Ceftriaxone 1 gram IV x1 in ER. Per chart note, acute resolving UTI, follow up with primary care physician 3-5 days. Urinalysis and urine culture are negative. Nitrofurantoin 100mg cap filled #10/5 on 4/6/2020 and ciprofloxacin 500mg tab filled #14/7 on 04/09/2020.

6	Santa Clara Valley Medical Center	06/19/2020	Chart note received. Home med list nitrofurantoin 100mg cap, #20/10 days from 6/19/20 to 6/28/2020. No claims.
7	Stanford Health Care	06/21/2020	Chart note reviewed. Rx for cefpodoxime x5 days, 1st dose given in ER. Denied claim for cefpodoxime 100mg tab #10/5 days on 7/2/2020 and 7/3/2020. No PA submitted.
8	El Camino Hospital	05/08/2020	Chart note reviewed. Discharge patient home oral antibiotics (not specified). No claims. Urinalysis negative.

Section 4 – Pharmacies

Pharmacy Locations

SCFHP has four 24-hour in-network pharmacies within Santa Clara County for members to access. In addition, the majority of retail chain pharmacies are opened until 9 P.M.

Table 4: 24-Hour In-Network Pharmacies in Santa Clara County

NABP	NPI	Pharmacy Name	Address	City	Zip
501507	1962417238	WALGREENS	121 E. EL CAMINO REAL	MT. VIEW	94040
514667	1730194002	WALGREENS	350 NORTH CAPITOL AVE.	SAN JOSE	95133
533011	1255346532	WALGREENS	440 BLOSSOM HILL ROAD	SAN JOSE	95123
552287	1710921549	CVS PHARMACY	2514 BERRYESSA RD	SAN JOSE	95132

Summary: Members with a diagnosis of UTI who do not have access to medications after an ER visit are at high risk for complications or readmissions. Approved claims were appropriate. There were no inappropriate denied claims. For no claims, 1 member had denied claims for cefpodoxime 11-12 days after the ER admission day. We implemented the point of sale message on 9/29/2020 for cefdinir as formulary alternative. No readmissions for the same diagnosis were found within this quarter.

Next Steps: Continue quarterly assessment of emergency prescription access with medical and pharmacy data. Follow up on members who did not have prescription claims to identify any trends and readmissions. Cases with potential barriers of care will be forwarded to SCFHP Quality Department.

Santa Clara Family Health Plan™

Pharmacy & Therapeutics Committee

DISCUSSION ITEMS

Pipeline Agents

Santa Clara Family Health Plan™

SANTA CLARA FAMILY HEALTH PLAN

Pipeline agents.

1st Quarter 2021

Abecma (ide-cel) (multiple myeloma)-BT†

2nd Quarter 2021

aducanumab (Alzheimer's)-BT†
Farxiga (CKD) –NI
Nurtec ODT (migraine prevention) –NI
Nuplazid (dementia-related psychosis)-NI*
relugolix/E2/NE (fibroids)-C
Rolontis (neutropenia)-C

3rd Quarter 2021

atogepant (migraine prevention) -C
avacopan (ANCA vasculitis) -BT
bimekizumab (plaque psoriasis) -C
Korsuva (pruritus with HD) -BT
sotorasib (lung cancer) -BT
Trikafta (cystic fibrosis) -NI
teplizumab (diabetes type 1, prevention) -BT
vosoritide (achondroplasia) -BT
abrocitinib, Olumiant & Rinvoq (atopic dermatitis) -C

4th Quarter 2021

Cilta-cel (multiple myeloma)-BT†
efgartigimod (myas. gravis)-BT†
roxadustat (anemia of CKD)-C
Verzenio (breast cancer) -NI

NOT YET FILED

tezepelumab (severe asthma) –BT

1Q21 2Q21 3Q21 4Q21 1Q22 ➡

KEY

C = Agent will **compete** with current standard of care
A = Agent will be used in **addition** to current therapy or expands the patient population treated
BT = Agent is a **breakthrough**/novel treatment in an area where no comparable drug therapy previously existed
NI = Previously approved agent with a **new indication** (high impact)
† = Medical Cost
* = Complete Response Letter
# = Emergency Use Authorization

Generic pipeline.

High impact

2Q2021

April 2021
Epaned
Lyrica CR

2Q2021
Absorica
Vascepa 0.5gm

June 2021
Perforomist*

3Q2021

1H2021
Chantix

Aug 2021
Sutent*

4Q2021

2H2021
Restasis*

Sept 2021
Bystolic

2021
Forteo
Durezol
Afinitor 10mg*
Byetta*
Kaletra tablets*

Nov 2021
Brovana*
Gilenya 0.25mg

Medium /Low impact

Bold font = new to slide
Red font = launched
**NO exclusivity*
ǂ Authorized Generic