



**STATE OF UTAH**  
**DEPARTMENT OF HEALTH**  
**DIVISION OF HEALTH CARE FINANCING**  
**DRUG UTILIZATION REVIEW (DUR)**  
**ANNUAL REPORT**  
**YEAR 2007**

## EXECUTIVE SUMMARY

The Utah Health Care Financing DUR Program Managers continue to deal with complex medical and drug issues. There have been multiple challenges this past year. The initiative to implement a preferred drug list was enacted in the legislature. Implementation of the Medicare Part-D Prescription Drug Plan began mid-year FY2006. As a consequence, FY2007 is the first complete year of program operation without prescription benefits to the dual eligible population. This has had an impact on all aspects of the program. 274,710 eligible clients were enrolled in the program. This figure includes approximately 23,000 dual eligible clients, and represents a total decrease of 12,849 from FY06. There were approximately 251,710 non-dual clients enrolled in the program. Total paid drug claims decreased \$46.5 million to \$ 136,418,644. The new State Phased Down Contributions (aka "Clawback") totaled \$ 21,695,489 bringing total program expense to \$158,114,133. The average cost of a prescription rose 3% to \$63.15. The average price of a brand name drug rose 14.6% to \$153.21. The average generic drug cost increased 9.6% to \$26.97. The total prescription volume was 2,160,456 down from 2,983,537 the previous year. Mental health drugs continue to account for almost 1/3 of all drug expenditures (34.5%). The atypical antipsychotics, the number one drug class ranked by cost, accounted for \$20.8 million. Antidepressant medications account for another \$10 million, and the anticonvulsant medications with continued increase in mental health uses totaled an additional \$15 million. Intense direct-to-consumer marketing by the Drug Manufacturers drives market share and increases use and spending. All reductions in spending this year are a direct result of the transfer of dual eligible clients to the Medicare Part-D program.

Efforts to control spending are aggressively being pursued. The contract with the University of Utah College of Pharmacy's Drug Regimen Review Center (DRRC) has achieved at least \$2.4 million in savings for FY07 simply by assisting physicians to reduce the number of prescriptions that could cause potential adverse drug reactions or elimination of unnecessary and/or duplicate prescriptions. The Division contracted with the DRRC to increase the number of reviews from 200 per month to 300 per month beginning with fiscal year 2004.

A program paid for by a grant from Eli Lilly and Company is focusing on mental health drugs. The program offers physician to physician consultations as well as sending out letters to physicians whose prescribing patterns are marked by a criteria driven computer program. The program has already demonstrated changes in prescribing patterns with subsequent improvements in health care delivery.

The DUR Board continues to serve well and has been instrumental in improving both quality of care and access to medications. The DUR Board has also been instrumental in improving healthcare outcomes and is directly responsible for influencing savings of over 16 million dollars.

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## I. INTRODUCTION

The Utah Department of Health, Division of Health Care Financing's Medicaid Drug Program continues to show upward trends in both cost and utilization even while the impact of the Medicare Modernization Act has lowered expenditures. Effective January 1, 2006 Medicare clients with eligibility in both the Medicare and the Medicaid programs, the so-called Dual Eligibles (DE), obtain their medications through the Medicare Part-D program. As a result, Fiscal Year 2007 is the first complete year without DE expenditures. Consequently, due to Part-D all aggregate totals have decreased, yet the Federal Government still requires the State to pay a portion of the costs associated with the DE clients that now receive drug benefits through the new Part-D Medicare Drug Plan. This portion has come to be known as the "Clawback".

Total drug spending totaled \$ 136,418,644\* for State Fiscal Year 2007 (FY07). "Clawback" payments for FY06 totaled \$ 21,695,489, bringing total expenditures to \$ 158,114,133. The total number of eligibles decreased from 287,559 to 274,710 or 4.4%. This represents a reversal from recent years where the number of eligible clients has steadily increased. The robust Utah economy may be responsible for the decline as members leave the program with improving employment opportunities. Since the number of DE clients (~23,000) has remained about the same, these declines are mostly attributable to the non-dual population. The number of recipients (those receiving prescriptions) decreased from 196,499 to 175,861 (10.5%). In spite of all these declines, spending rose from \$761.64 per recipient per year (PRPY) to \$775.72, an increase of \$14.08 (1.8%). Costs continue to rise for those Medicaid clients using prescription drugs.

Medicaid paid for 2,160,456 prescriptions. This is a decrease of 27.6% compared to FY06. The average cost per prescription increased by \$1.81, a rise of 3%. This increase in prescription costs amounts to \$3,910,425.

The average price of a generic drug prescription increased 9.6% to \$26.97. Average brand name prescription prices rose 14.6% to \$153.21, an increase of \$19.58 per prescription. The Pharmacy Practice Act mandates the use of generics in the Medicaid drug program. Overall generic usage increased 3.97% from FY06, and this shift to generic drugs means \$10,827,617 in savings for FY07.

## II. RETURN ON INVESTMENT

### Drug Rebates

Drug rebates from the manufacturers continue to be the most significant savings to the drug program. The rebate goes back into the State general fund and is shared with the Federal Government. The total rebate collected from 1994 through 2007YTD exceeds \$320,000,000\*. **Table 1** shows rebates collected from 1994 to 2007\*\*. A breakout of the rebate is shown in *Attachment 1*. Including the recent billings for the third quarter of calendar year 2007, there are approximately \$9,918,554 in uncollected rebates at the present time.

\* All dollar amounts shown include both state and federal dollars unless otherwise noted!  
\*\*as of 09/30/07

**Table 1**  
**Drug Rebate by Calendar Year\***

Year	Dollar amount collected
'94	\$ 7,834,306
'95	\$ 8,618,615
'96	\$ 8,883,947
'97	\$ 10,109,430
'98	\$ 14,375,172
'99	\$ 17,940,610
'00	\$ 20,984,875
'01	\$ 24,841,849
'02	\$ 29,277,645
'03	\$ 35,151,932
'04	\$ 44,496,665
'05	\$ 52,459,164
'06	\$ 32,884,697
Calendar '07TD	\$ 18,927,467
Totals	\$326,786,374

\* All dollar amounts shown include both state and federal dollars unless otherwise noted!  
 Figures since FY2006 are lower due to the exodus of dual eligible clients from the program  
 Figures will differ from previous years due to manufacturer adjustments

### **Prior Approval**

The mandate for the use of generics vs brand name drugs has been cost effective. Brand name drugs for which a generic is available have been placed on prior approval, and as mentioned previously the FY07 savings for this initiative amounts to over \$10.8 million. Prior authorizations are also used to control inappropriate and excessive use for very expensive medications. All totaled in FY06, there were 9,043 prior authorizations issued.

### **Drug Regimen Review Center**

The University Of Utah College of Pharmacy's Drug Regimen Review Center (DRRC) began reviewing high prescription utilizers of the Medicaid drug program in 2002. The DRRC contacts physicians who prescribe for an identified Medicaid client and performs an educational 'Peer Review' of the targeted client. The selection is based on the paid drug claim history. The goal is to reduce waste, duplication and unnecessary prescription utilization, and the program has been well received by providers and clients. As of June 30, 2007 there have

been 33,841 letters sent to 7,317 prescribers with recommendations concerning 9,292 Medicaid clients. For FY07, it appears that the DRRC program achieved at least \$2,441,672 savings (assuming no baseline increase in drug costs) by assisting physicians to be able to reduce the number of prescriptions that could cause potential adverse drug reactions or elimination of unnecessary and/or duplicate prescriptions. The DRRC is contracted with the Department for \$468,000/year. *Attachment 2* is the FY07 report from the DRRC.

### **Behavior Pharmacy Management System**

The Division has been working on a program known as the Behavioral Health Pharmacy Management System (BPMS) Program which is administered by Comprehensive Neuroscience, Inc.. This Program has now been in operation since March '04 and is focused on mental health drug usage as identified in retrospective drug utilization review (RETRODUR) analysis. A total of 2,733 providers were notified in writing about the advent of this program. Utah psychiatrists provide physician to physician consultation with targeted physicians who can benefit from their expertise.

BPMS reviews and analyzes Medicaid paid drug claim history for behavioral health medication and compares these claims against a series of best practices quality indicators. Some of the key quality indicators are:

- Prescribing two or more Atypical Antipsychotics
- Children and Adolescents receiving three or more Psychotropics
- Multiple Prescribers of Any Class of Behavioral Health Drug
- Polypharmacy (e.g. patients receiving 3 or more anti-depressants)

The Division is pleased to report positive response to the program. For those prescribers receiving notification of prescribing patterns that may be at variance with the best practice guidelines, there have been changes in prescribing practices that are more consistent with these guidelines.

A key indicator is "Multiple Prescribers of the same class of psychotropic drug for 45 days or more." All prescribers who write scripts for behavioral health drugs receive notification if their patient is also receiving prescriptions in the same class of drugs from another prescriber. For example, during February 2007, 1,219 letters were mailed out regarding various indicators that have been activated for adult and child clients. Unfortunately, mailings have been temporarily halted since that time due to a federally commissioned analysis of the program to determine its effectiveness. Therefore, change data are not available at this time. Mailings have only recently been undertaken anew with improved methodology. Looking back on a previous nine month period from January 2006 through September 2006, however, the number of multiple prescribers was reduced by 68% (*Attachment 3*). This response indicates a willingness of prescribers to modify their practices when provided with feedback and information about best practices and clinical guidelines. This is particularly gratifying since minimizing the incidences of multiple prescribers is a significant factor in reducing potential toxicity as well as increasing coordination of care. *Attachment 3* shows targeted change reports for prescribers and targeted change reports for patients in regard to mental health drugs, and demonstrates the type of impact on prescribing practices sought through this program.

The BPMS program is paid for by a grant from Eli Lilly and Company and was renewed this year. Between the BPMS and DRRC, more than 9,725 retrospective letters were mailed to physicians, in an effort to bring prescribing practices more in line with evidence based medicine.

**Co-Pay**

Co-pays returned \$4,185,931 for FY07 and \$1,827,322 for FY08 year to date (YTD) (7/1/07 - 11/29/07). Co-pays are collected on prescriptions for recipients in the Primary Care Network program and the Non-traditional Medicaid Program. No co-pays are collected in the traditional program for certain exempt categories of recipients, e.g. children under age 18, pregnant women, some nursing home residents, and family planning prescriptions. Table 2 shows total co-payments collected to date:

**Table 2  
Co-Payments Collected**

Fiscal year	Amount Returned
FY 1998	\$ 411,472
FY 1999	\$ 833,201
FY 2000	\$ 894,260
FY 2001	\$ 992,320
FY 2002	\$ 1,072,334
FY 2003	\$ 3,286,039
FY 2004	\$ 5,582,844
FY 2005	\$ 5,862,754
FY 2006	\$ 5,000,728
FY 2007	\$ 4,185,931
FY 2008YTD	\$1,827,322
Total	\$ 29,949,205

Figures since FY2006 are lower due to the exodus of dual eligible clients from the program

**III. FINANCIAL DATA FOR DRUG PROGRAM**

All data presented at DUR Board meetings and in this report are referenced to gross paid claims from the data-warehouse. Final year-end dollar and unit amounts may be different due to ledger adjustments taken by Division of Finance office of fiscal operations. All FY07 program total figures show decreases due to being the first complete year of data without the DE clients. All direct comparisons with FY06 data will be made with the DE clients factored out where possible.

Spending per Medicaid recipient increased by \$14.08 for a total of \$2,476,122. This is less of an increase than the PRPY increase in FY06, and represents a 63% decline. Rises in spending continue to be due to increased utilization and price increases however. Table 3 shows a summary of the drug program.

**Table 3  
Drug Program Summary**

Fiscal Year	FY 2001	FY2002	FY03	FY04	FY05	FY06	FY07	FY08TD (5 months)
Total Eligibles	235,813	249,447	249,745	276,813	286,983	287,559	274,710	NA
Total Rx Recipients	135,947	147,186	174,952	194,067	200,505	196,499	175,861	110,107
Total Rx	2,508,176	2,649,188	2,905,334	3,288,347	3,474,297	2,983,871	2,160,456	809,288
Dollars Paid Out	113,651,609	134,495,292	159,546,679	183,306,089	207,580,360	183,028,972	136,418,644	54,180,448
% yearly budget increase	18.1%	18.3%	18.6%	14.9%	13.2%	(11.8%)	(25.5%)	NA
Average Cost/RX	45.31	50.77	54.92	55.74	59.75	61.34	63.15	66.95
% increase in cost/RX	10.3%	12.0%	8.2%	1.5%	7.2%	2.7%	3.0%	6.0%
Ave. Rx/month per Eligible	0.89	0.89	0.97	0.99	1	0.86	0.65	NA
Ave. Rx/month per recipient	1.54	1.5	1.38	1.41	1.44	1.26	1.02	1.47
% change in RX/Mo. per recipient	8.6%	(2.4%)	(7.7%)	2%	2.29%	(12.36%)	(19%)	44%

Figures since FY2006 are lower due to the exodus of dual eligible clients from the program.

### Top Twelve Therapeutic Classes

Table 4 shows the top twelve therapeutic classes ranked by cost for FY07. The atypical antipsychotics remain the number one drug expenditure. Since anticonvulsants are used extensively in mental health for bi-polar and other mood disorders and in neuropathic pain treatment, it's not surprising that they are ranked at number two. Bearing that in mind, mental health drug costs account for over 1/3 of the total drug costs. Five of the top twelve drug classes are used for mental health. The newest mental health classification, atypical antipsychotics, is separated from other existing mental health drug classes. The number one class in the atypical antipsychotics, H7T, is made up of a very small group of five drugs. H7X is a single drug category still referred to as an atypical antipsychotic and will continue to be included with H7T. By itself this single drug would rank number seven based on cost. Only six drugs (drug classes H7T and H7X) account for \$20.8 million.

**Table 4**  
**Top Twelve Therapeutic Classes By Cost, And By Volume For FY2007**

	RANKED BY COST - FY2007	COST - FY2006	% CHANGE FROM FY05	DRUG CLASS	RANKED BY PRESCRIPTION VOLUME - 2007	RANKED BY PRESCRIPTION VOLUME - 2006	Ave. cost/RX for FY07
1	\$20,846,927	\$28,837,409	(27.7%)	H7T / H7X ATYPICAL ANTIPSYCHOTICS	5	7	\$280.02
2	\$15,418,762	\$18,303,429	(15.7%)	H4B ANTICONVULSANTS	2	2	\$119.43
3	\$7,740,370	\$10,045,656	(23%)	H3A NARCOTIC ANALGESICS	1	1	\$39.47
4	\$7,219,816	\$10,559,530	(31.6%)	D4K ANTI-ULCER, PPIs	6	4	\$89.52
5	\$5,405,630	\$8,541,844	(36.7%)	H2S ANTIDEPRESSANTS (SSRIs)	4	3	\$57.18
6	\$3,368,095	\$4,197,527	(19.8%)	M0E HEMOPHILIA FACTOR VIII	209	200	\$8,680.66
7	\$3,354,617	\$3,820,880	(12.2%)	H7C SEROTONIN- NOREPINEPHRINE REUPTAKE-INHIB.	19	25	\$128.28
8	\$2,991,549	\$5,368,754	(44.3%)	M4D/M4E/M4I/M4L/M4M LIPOTROPICS	13	10	\$85.98
9	\$2,448,313	\$2,649,288	(7.6%)	H2E SEDATIVE/HYPNOTICS	16	17	\$72.35
10	\$2,348,721	\$2,831,453	(17%)	C4G INSULINS	25	24	\$112.84
11	\$2,262,752	\$2,049,447	10.4%	H2V ADHD / NARCOLEPSY	24	32	\$102.98
12	\$2,103,175	\$2,595,387	(19%)	H7D NOREPI / DOPAMINE REUPTAKE INHIBITORS	26	28	\$99.30

Figures since FY2006 are lower due to the exodus of dual eligible clients from the program

### Brand Name vs. Generic

A generic drug is identical when bio-equivalent to a brand name drug in dosage form, safety, strength, route of administration, quality, performance, characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the branded price. In FY07, the average cost spread between the name brand price and generic was \$126.24, an increase of \$17.22. The use of generic drugs continues to be the single most important cost saving measure that can be utilized.

Table 5 shows the breakout of dispensing fees and also shows the brand name (B) vs. generic name (G) utilization for prescriptions for FY07. The use of generics when available has caused an additional shift of 3.97% to generics from brand name drugs this past year. This equates to 85,770 prescriptions. All brand name drugs require a prior approval if there is a generic available. Brand name drugs account for approximately 27.96% of claims while generics account for approximately 62.19% of all claims. OTC and select I.V. drugs make up the rest. Brand name drugs still account for 67.75% of total dollars spent. Savings generated from switching to generics calculates to over \$10.8

million in FY07.

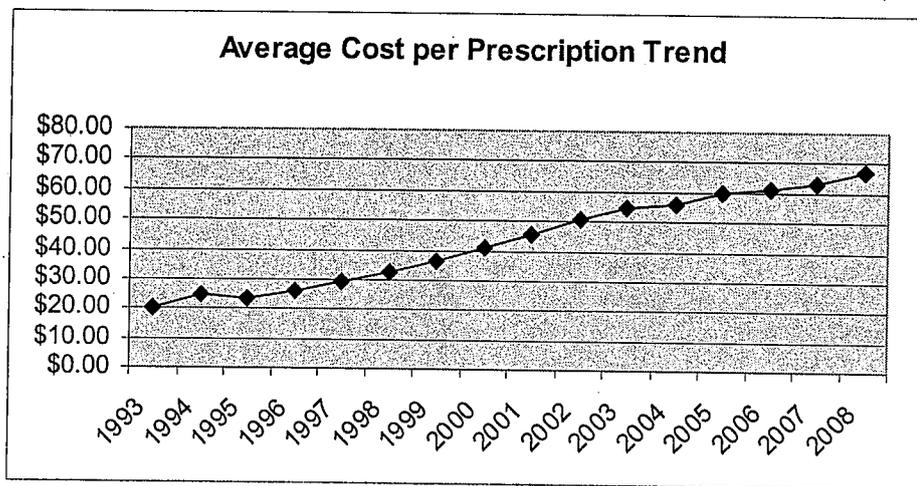
Dispensing fee indicators "F, J, K, L, M" are for select home intravenous infusion prescriptions. Dispensing fee indicator "C" is for over-the-counter products including insulins.

**Table 5  
Utilization By Dispensing Fee Indicator**

Allowed Dispensing Source	# Rx	% of Rx's	Total Cost	ave. cost per RX (FY07)	ave. cost per RX (FY06)	% change for FY07 compared to FY06
Brand	603,216	27.96%	\$92,421,167.36	\$153.21	\$133.63	12.78%
C	206,310	9.56%	\$6,954,606.39	\$33.71	\$31.71	5.93%
F	1,262	0.06%	\$4,445.20	\$3.52	\$4.44	(26.14%)
Generic	1,341,711	62.19%	\$36,188,468.05	\$26.97	\$24.61	8.75%
J	697	0.03%	\$81,587.03	\$117.05	\$177.43	(51.58%)
K	549	0.03%	\$535,927.76	\$976.19	\$599.83	38.55%
L	1,000	0.05%	\$30,137.90	\$30.14	\$29.17	3.22%
M	139	0.01%	\$1,509.23	\$10.86	\$10.12	6.81%
	2,577	0.12%	\$200,818.64	\$77.93	N/A	N/A

Figure 1 shows a graphic representation of the increase in prescription prices over the most recent 16 year period.

**Figure 1**



The 3% increase in the average price of a prescription for FY07 reflects a lower increase than customary in the past 7 years. This lower rate is mainly due to increased use of generic drugs and the migration of more expensive DE client prescriptions to the Medicare part-D program. The average price for a prescription has already increased 6.0% in the first five months of FY08.

## Clawback

With the Medicare Part-D prescription drug plan, the Federal government requires that the States continue to pay a portion of the costs associated with the prescriptions that are now provided through Medicare Part-D. This portion, called the "State Phased Down Contribution", is remitted on a monthly basis to the Federal Government by what has come to be known as the "Clawback" payment. This payment is calculated monthly based on FY03 eligibility data, and factored per DE client. **Table 6** contains Calendar Year totals for each month's remittance since the inception of Part-D in January 2006. When FY07 Clawback amounts are added to FY07 Medicaid expenditures the total program costs are \$ 158,114,133.

**Table 6**  
**State Phased Down Contribution**  
**"Clawback"**

Jul 2006	\$ 1,703,749.50
Aug 2006	\$ 1,711,368.85
Sep 2006	\$ 1,721,266.15
Oct 2006	\$ 1,758,088.91
Nov 2006	\$ 1,768,686.73
Dec 2006	\$ 1,762,159.98
Jan 2007	\$ 1,837,220.41
Feb 2007	\$ 1,840,918.50
Mar 2007	\$ 1,940,792.87
Apr 2007	\$ 1,889,564.63
May 2007	\$ 1,881,461.31
Jun 2007	\$ 1,880,211.42
<b>SFY2007 Total:</b>	<b>\$21,695,489.26</b>

## IV. PATIENT COUNSELING

The State Board of Pharmacy, under the direction of the Division of Commerce and Professional Licensing is responsible for identifying pharmacists who do not counsel. Last year, no pharmacists were cited for failure to counsel Medicaid Clients.

## V. DRUG UTILIZATION REVIEW

### PRODUR

For FY07, the Prospective Drug Utilization Review (PRODUR) program returned \$5,242,826 due to reversed claims. It should be recognized that in actual dollars this amount may be smaller since physicians may substitute different prescriptive drugs for those than were discontinued (reversed) due to warnings (*Figures for FY07 are the result of an eleven month calculated average due to a computer programming problem that occurred for the monthly report of July 2006. A corrected report for this month has not yet posted. Figures for FY06 are also calculated on partial year information*). The PRODUR Program ran against 2,160,456 claims for this partial year, of which a calculated 69,460 claims were reversed. More than 31% of submitted claims resulted in an adverse drug warning being posted to the pharmacy. Of those claims with warnings, 10.2 % were reversed, an increase of 1.7% over the previous year. Note that there continues to be a gradual increase in warnings posted to total claims generated. Table 7 shows the trend in number of occurrences in the State's PRODUR for just one of the indicators, THERAPEUTIC DUPLICATION, over a nine-year period.

**Table 7**  
**PRODUR Therapeutic Duplications**

Year	Total therapeutic duplication warnings
1999	121,584
2000	134,596
2001	149,294
2002	154,441
2003	162,135
2004	196,356
2005	198,939
2006 Calculated*	154,636
2007 Calculated*	117,941

Figures since FY2006 are lower due to the exodus of dual eligible clients from the program.

For therapeutic duplication, there was a 23.72% calculated decrease in the number of warnings in FY07. This decrease is largely attributable to the loss of DE clients. Over the seven year period from 1999 through 2005, there was a 64% increase in therapeutic duplication warnings. As more complex new drugs come to market and more prescriptions are used per recipient per year, the chances for serious adverse drug events continue to increase. **Therapeutic duplication continues to be a major issue!** It is to the credit of both physicians' and pharmacists' responses to PRODUR that many probable adverse drug events are avoided. The past three years through the CNS program, RETRODUR has focused on over utilization of mental health drugs that often are therapeutic duplications. Too frequently, two or more atypical antipsychotics are being prescribed while other centrally acting drugs are being prescribed concomitantly. In addition, the DRRC has focused much of its work on therapeutic duplications.

## DUR BOARD ACTIVITIES - RETRODUR

As discussed previously, both the Drug Regimen Review Center and the Behavioral Pharmacy Management System are retrospective drug utilization review (RETRODUR) based programs.

The DUR Board is a group of volunteers, nominated by their respective professional organizations, whose charge it is to monitor the Medicaid Drug Program and look for opportunities to eliminate waste, adverse drug reactions, drug over utilization and fraud. The Board consists of physicians, pharmacists, a dentist, a community advocate and a representative from the Pharmaceutical Research and Manufactures Association (PhRMA). The DUR Board is mandated by both state and federal law. The Board meets monthly and meetings are open to the public. Each month the DUR Board deals with several petitions from physicians seeking drug coverage outside policy and/or criteria guidelines. This past year the DUR Board approved 34% of these petitions and denied or suspended the rest. Frequently the Board requests additional information from the petitioner. When dealing with petitions, board members have a printout of each client's drug utilization history for twelve months from which to make decisions. Clients are not identified by either name or ID number, so confidentiality is maintained. All petitions that are rejected still have the option of requesting a formal hearing. To date, no DUR Board decision has been over turned by a hearing.

During FY07, the DUR Board placed limits or restrictions on 8 drugs or drug groups. All of these restrictions were placed in order to assure more appropriate utilization of the medications involved. Savings continue to be realized from previous DUR actions as well. Some DUR activities are reviewed below:

1. A limit to restrict coverage of a new smoking deterrent to 24 weeks lifetime maximum benefit. Smoking cessation products are an optional coverage choice for Medicaid. This product boasts both a higher effectiveness and cost. However, like other cessation products it is still far from 100% effective. It must be used in conjunction with a "Committed Quitters" program. Coverage for smoking cessation products in both FY06 and FY05 totaled ~\$85,000 yearly for ~1,100 prescriptions each year. The introduction of this product increased prescriptions by a factor of 2.3, and cost for the category by \$146,301 to a total of \$223,052, or over 170%.
2. Medications used for the symptomatic control of cough and cold are an optional exclusion under the OBRA laws that establish Medicaid prescription coverage. The DUR Board approved coverage for a limited number of agents from this class in mid-FY06. \$1,120,000 were spent in each of FY05 and FY06 for these products. Expenditures for FY07 were \$711,587, generating a \$408,400 savings.
3. A prior authorization was placed on a new antipsychotic drug to ensure appropriate use of lower cost alternatives that are equally as safe and effective. This drug is the active metabolite of an existing branded drug,

and is produced by the same manufacturer. The older branded drug loses patent protection in 2008 exposing sales to the threat of conversion to generics. This new product is intended to convert existing sales of the existing branded drug to the new drug. The cost of the existing branded drug to Medicaid has averaged \$4 million per year over the last 3 years. This prior authorization kept appropriate use of this drug intact - only 95 prescriptions were authorized in FY07 vs. 14,355 prescriptions of the existing branded drug. Since the cost difference between the two is about five-fold, this has maintained a potential savings of around \$16,000,000.

4. In late FY05, the DUR Board placed a quantity limit on narcotic analgesic, single agent medications used for the treatment of pain. Savings amounting to \$1,248,000 were realized for FY06. Expenditures for this category have decreased from a high of \$7.7 million in FY05 to \$4.3 million in FY07. Savings for FY07 were projected to be at \$1.3 million, but \$2.2 million were realized.

The DUR Board spent significant time in discussions regarding the implementation of the new Preferred Drug List and the formation and function of a Pharmacy and Therapeutics Committee. This new savings tool was delayed in its realization until after the Fiscal year had ended. Savings for this fiscal year were not possible.

The DUR Board also undertook a review of several existing categories including Synagis®, growth hormones, erythropoietin agents, and ICD-9 requirements for antipsychotic medications, and determined to maintain the current controls in place for all these groups. Throughout the year, the DUR Board passed restrictions, either through prior authorization, quantity limits, or cumulative limits on other agents as well. The majority were new product entries which lack historical data to compare against for savings calculations.

## **VI. CONSUMER PRICE INDEX (CPI)**

There has been a 3% increase in the average cost of prescriptions for Utah Medicaid for the fiscal year 2007 while the federal government cites a 0.9% increase in the CPI for prescription drugs as of July 2007. The average price of a prescription increased 6.0% in the first five months of FY08 for the Medicaid program.

The use of more generic drugs contributes to a lower rate of increase for drug prices. Table 8 shows CPI for prescription drugs, medical care, and all products for a ten year period.

**Table 8  
Consumer Price Index**

FISCAL YEAR Jul 1-Jun 30	PRESCRIPTION DRUGS	MEDICAL CARE	ALL ITEMS
1997	2.8	2.7	2.2
1998	3.8	3.4	1.7
1999	5.8	3.3	2
2000	4.2	4.4	3.7
2001	5.7	4.6	2.7
2002	5.3	5.3	1.5
2003	2.7	4.3	2.1
2004	3.5	5.2	3.0
2005	3.4	4.8	3.2
2006	4.6	4.0	4.1
2007	0.9	5.4	2.4

## VII. CONCLUSION

The Medicaid Drug program returned more than \$50.3 million to the Department when drug rebates, co-pays, prior approvals/limits and the College of Pharmacy's DRRC activities are factored in. This year, in addition to these savings, the total drug program costs ("Clawback" included) decreased \$34.9 million to \$158,114,133 due to the departure of the Medicare Dual Eligible clients to the Medicare Part-D prescription drug plan. In spite of this, increases in prescriptions per recipient and rising drug costs continue to off-set overall savings. The brand-name prior approval initiative again returned over \$10.8 million in FY06. Various tools are used to effect savings to the Medicaid Drug Program while at the same time providing one of the most robust and generous drug benefits in the Nation.

A preferred drug list was not available for FY07, but will be for FY08. Other initiatives that are not part of Drug Utilization Review such as the Hemophilia program and 340B pricing are not reported here. Both programs currently operate within the Medicaid program.

The DUR Board continues to play an active role in the Medicaid Drug Program, and the Division is fortunate to have DUR Board members with high community profiles and acknowledged expertise in their fields. The Division also benefits from in-house control of the entire drug program.

# ATTACHMENT 1

Attachment 1

**Drug Rebate by Calendar Year\***

Year	Dollar amount collected
'94	\$ 7,834,306
'95	\$ 8,618,615
'96	\$ 8,883,947
'97	\$ 10,109,430
'98	\$ 14,375,172
'99	\$ 17,940,610
'00	\$ 20,984,875
'01	\$ 24,841,849
'02	\$ 29,277,645
'03	\$ 35,151,932
'04	\$ 44,496,665
'05	\$ 52,459,164
'06	\$ 32,884,697
Calendar '07TD	\$ 18,927,467

All dollar amounts shown include both state and federal dollars unless otherwise noted!  
 Figures since FY2006 are lower due to the exodus of dual eligible clients from the program.  
 Figures will differ from previous years due to manufacturer adjustments.  
 \* as of 06/30/06

Rebates are invoiced and totals tracked by Calendar Year. Deposited receipts are tabulated by Fiscal Year (see next three pages).

PHARMACEUTICAL REBATES  
RECEIVABLE REPORT BY CALENDAR QUARTER

29-Nov-07

CALENDAR YEAR 1993 \$ 2,795,687.00 \$ 2,795,687.00

CALENDAR YEAR 1994

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1994	\$ 3,105,589.06	\$ 1,843,818.09	\$ 1,843,818.09	100.00%	\$ -
2ND QTR. 1994	\$ 2,885,148.99	\$ 1,919,503.13	\$ 1,919,503.13	100.00%	\$ -
3RD QTR. 1994	\$ 2,245,488.01	\$ 1,882,544.90	\$ 1,882,544.90	100.00%	\$ -
4TH QTR. 1994	\$ 2,317,731.16	\$ 2,181,388.55	\$ 2,181,388.55	100.00%	\$ -
TOTAL CAL. 1994	\$ 10,553,957.22	\$ 7,827,254.67	\$ 7,827,254.67	100.00%	\$ -
		\$ 10,522,941.67	\$ 10,522,941.67		

CALENDAR YEAR 1995

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1995	\$ 2,351,256.06	\$ 1,915,754.76	\$ 1,915,754.76	100.00%	\$ -
2ND QTR. 1995	\$ 1,999,609.38	\$ 2,063,064.91	\$ 2,063,064.91	100.00%	\$ -
3RD QTR. 1995	\$ 2,014,504.61	\$ 2,404,131.96	\$ 2,404,131.96	100.00%	\$ -
4TH QTR. 1995	\$ 2,173,643.05	\$ 2,234,972.16	\$ 2,234,972.16	100.00%	\$ -
TOTAL CAL. 1995	\$ 8,539,013.10	\$ 8,617,923.79	\$ 8,617,923.79	100.00%	\$ -
		\$ 19,240,865.46	\$ 19,240,865.46		

CALENDAR YEAR 1996

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1996	\$ 2,275,314.58	\$ 2,267,262.43	\$ 2,267,262.43	100.00%	\$ -
2ND QTR. 1996	\$ 2,401,796.89	\$ 2,159,095.40	\$ 2,159,095.40	100.00%	\$ -
3RD QTR. 1996	\$ 2,022,344.20	\$ 2,332,374.91	\$ 2,332,374.91	100.00%	\$ -
4TH QTR. 1996	\$ 1,968,050.11	\$ 2,123,732.81	\$ 2,123,732.81	100.00%	\$ -
TOTAL CAL. 1996	\$ 8,667,505.78	\$ 8,882,465.55	\$ 8,882,465.55	100.00%	\$ -
		\$ 28,123,331.01	\$ 28,123,331.01		

CALENDAR YEAR 1997

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1997	\$ 2,267,909.46	\$ 2,453,330.43	\$ 2,452,765.16	99.98%	\$ 565.27
2ND QTR. 1997	\$ 2,272,392.08	\$ 2,470,618.20	\$ 2,470,500.46	100.00%	\$ 117.74
3RD QTR. 1997	\$ 2,256,068.59	\$ 2,522,481.33	\$ 2,522,481.33	100.00%	\$ -
4TH QTR. 1997	\$ 2,761,901.09	\$ 2,663,369.72	\$ 2,663,683.54	100.01%	\$ (313.82)
TOTAL CAL. 1997	\$ 9,558,271.22	\$ 10,109,799.68	\$ 10,109,430.49	100.00%	\$ 369.19
		\$ 38,233,130.69	\$ 38,232,761.50		

CALENDAR YEAR 1998

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF CURRENT BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1998	\$ 3,136,068.65	\$ 3,444,369.25	\$ 3,443,564.25	99.98%	\$ 805.00
2ND QTR. 1998	\$ 3,317,852.16	\$ 3,544,985.37	\$ 3,543,735.81	99.96%	\$ 1,249.56
3RD QTR. 1998	\$ 3,340,437.06	\$ 3,511,985.76	\$ 3,511,371.30	99.98%	\$ 614.46
4TH QTR. 1998	\$ 3,581,055.21	\$ 3,877,418.10	\$ 3,876,501.17	99.98%	\$ 916.93
TOTAL CAL. 1998	\$ 13,375,413.08	\$ 14,378,758.48	\$ 14,375,172.53	99.98%	\$ 3,585.95
		\$ 52,611,889.17	\$ 52,607,934.03		

DEPOSITS BY  
QUARTERS

JUL/SEP 98	\$ 3,623,585.13
OCT/DEC 98	\$ 4,043,893.79
JAN/MAR 99	\$ 2,898,491.26
APR/JUN 99	\$ 3,492,770.57
TOTAL	\$ 14,058,740.75

CALENDAR YEAR 1999

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1999	\$ 4,098,810.25	\$ 4,439,147.43	\$ 4,414,434.81	99.44%	\$ 24,712.62
2ND QTR. 1999	\$ 3,971,797.68	\$ 4,348,064.95	\$ 4,347,074.16	99.98%	\$ 990.79
3RD QTR. 1999	\$ 3,584,477.52	\$ 4,373,455.87	\$ 4,372,295.52	99.97%	\$ 1,160.35
4TH QTR. 1999	\$ 3,950,086.89	\$ 4,812,880.11	\$ 4,806,806.22	99.87%	\$ 6,073.89
TOTAL CAL. 1999	\$ 15,605,172.34	\$ 17,973,548.36	\$ 17,940,610.71	99.82%	\$ 32,937.65
		\$ 70,585,437.53	\$ 70,548,544.74		

DEPOSITS BY  
QUARTERS

JUL/SEP 99	\$ 4,167,622.42
OCT/DEC 99	\$ 4,752,941.22
JAN/MAR 00	\$ 4,456,129.22
APR/JUN 00	\$ 4,804,544.99
TOTAL	\$ 18,181,237.85

CALENDAR YEAR 2000

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2000	\$ 4,653,532.41	\$ 4,813,366.12	\$ 4,809,536.74	99.92%	\$ 3,829.38
2ND QTR. 2000	\$ 4,693,461.12	\$ 5,240,627.47	\$ 5,238,548.45	99.96%	\$ 2,079.02
3RD QTR. 2000	\$ 4,584,590.40	\$ 5,586,891.83	\$ 5,584,038.33	99.95%	\$ 2,853.50
4TH QTR. 2000	\$ 4,768,266.85	\$ 5,357,093.84	\$ 5,352,751.98	99.92%	\$ 4,341.86
<b>TOTAL CAL. 2000</b>	<b>\$ 18,699,850.78</b>	<b>\$ 20,997,979.26</b>	<b>\$ 20,984,875.50</b>	<b>99.94%</b>	<b>\$ 13,103.76</b>

\$ 91,583,416.79 \$ 91,533,420.24

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/00

**\$ 49,996.55**

DEPOSITS BY QUARTERS

JUL/SEP 00	\$ 8,178,771.73
OCT/DEC 00	\$ 4,670,717.47
JAN/MAR 01	\$ 2,022,213.34
APR/JUN 01	\$ 6,355,762.22
<b>TOTAL</b>	<b>\$ 21,227,464.76</b>

CALENDAR YEAR 2001

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2001	\$ 5,958,760.19	\$ 6,278,010.44	\$ 6,274,404.44	99.94%	\$ 3,606.00
2ND QTR. 2001	\$ 5,707,519.93	\$ 6,248,281.54	\$ 6,237,769.23	99.83%	\$ 10,512.31
3RD QTR. 2001	\$ 5,381,010.65	\$ 6,072,044.98	\$ 6,070,769.38	99.98%	\$ 1,275.60
4TH QTR. 2001	\$ 6,104,435.76	\$ 6,271,160.24	\$ 6,258,906.33	99.80%	\$ 12,253.91
<b>TOTAL CAL. 2001</b>	<b>\$ 23,149,726.53</b>	<b>\$ 24,869,497.20</b>	<b>\$ 24,841,849.38</b>	<b>99.89%</b>	<b>\$ 27,647.82</b>

\$ 116,452,913.99 \$ 116,375,269.62

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/01

**\$ 77,644.37**

DEPOSITS BY QUARTERS

JUL/SEP 01	\$ 8,901,272.80
OCT/DEC 01	\$ 4,881,175.52
JAN/MAR 02	\$ 4,284,280.29
APR/JUN 02	\$ 6,751,587.99
<b>TOTAL</b>	<b>\$ 24,818,316.60</b>

CALENDAR YEAR 2002

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2002	\$ 6,780,557.91	\$ 6,985,078.74	\$ 6,982,498.22	99.96%	\$ 2,580.52
2ND QTR. 2002	\$ 7,095,221.57	\$ 7,333,706.84	\$ 7,332,449.26	99.98%	\$ 1,257.58
3RD QTR. 2002	\$ 6,784,359.90	\$ 7,131,383.39	\$ 7,127,454.77	99.94%	\$ 3,928.62
4TH QTR. 2002	\$ 7,206,602.96	\$ 7,844,906.07	\$ 7,835,243.51	99.88%	\$ 9,662.56
<b>TOTAL CAL. 2002</b>	<b>\$ 27,866,742.34</b>	<b>\$ 29,295,075.04</b>	<b>\$ 29,277,645.76</b>	<b>99.94%</b>	<b>\$ 17,429.28</b>

\$ 145,747,989.03 \$ 145,652,915.38

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/02

**\$ 95,073.65**

DEPOSITS BY QUARTERS

JUL/SEP 02	\$ 6,482,301.55
OCT/DEC 02	\$ 9,850,166.71
JAN/MAR 03	\$ 4,590,624.34
APR/JUN 03	\$ 7,565,968.07
<b>TOTAL</b>	<b>\$ 28,489,060.67</b>

CALENDAR YEAR 2003

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2003	\$ 8,292,681.95	\$ 8,555,403.37	\$ 8,553,067.88	99.97%	\$ 2,335.49
2ND QTR. 2003	\$ 8,545,644.32	\$ 8,413,491.65	\$ 8,395,925.46	99.79%	\$ 17,566.19
3RD QTR. 2003	\$ 8,851,856.67	\$ 8,525,530.59	\$ 8,522,123.54	99.96%	\$ 3,407.05
4TH QTR. 2003	\$ 9,504,983.09	\$ 9,681,189.46	\$ 9,680,815.50	100.00%	\$ 373.96
<b>TOTAL CAL. 2003</b>	<b>\$ 35,195,166.03</b>	<b>\$ 35,175,615.07</b>	<b>\$ 35,151,932.38</b>	<b>99.93%</b>	<b>\$ 23,682.69</b>

\$ 180,923,604.10 \$ 180,804,847.76

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/03

**\$ 118,756.34**

DEPOSITS BY QUARTERS

JUL/SEP 03	\$ 8,722,217.90
OCT/DEC 03	\$ 12,387,001.01
JAN/MAR 04	\$ 5,403,714.10
APR/JUN 04	\$ 14,861,903.08
<b>TOTAL</b>	<b>\$ 41,374,836.09</b>

CALENDAR YEAR 2004

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2004	\$ 9,137,150.78	\$ 10,940,131.51	\$ 10,909,385.95	99.72%	\$ 30,745.56
2ND QTR. 2004	\$ 11,962,383.22	\$ 11,699,040.43	\$ 11,662,477.65	99.69%	\$ 36,562.78
3RD QTR. 2004	\$ 10,726,511.63	\$ 10,442,060.17	\$ 10,411,877.18	99.71%	\$ 30,182.99
4TH QTR. 2004	\$ 11,953,479.21	\$ 11,544,930.70	\$ 11,512,925.00	99.72%	\$ 32,005.70
<b>TOTAL CAL. 2004</b>	<b>\$ 43,779,524.84</b>	<b>\$ 44,626,162.81</b>	<b>\$ 44,496,665.78</b>	<b>99.71%</b>	<b>\$ 129,497.03</b>

\$ 225,549,766.91 \$ 225,301,513.54

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/04

**\$ 248,253.37**

DEPOSITS BY QUARTERS

JUL/SEP 04	\$ 6,102,082.71
OCT/DEC 04	\$ 12,252,445.01
JAN/MAR 05	\$ 9,753,532.45
APR/JUN 05	\$ 17,238,046.33
<b>TOTAL</b>	<b>\$ 45,346,106.50</b>

CALENDAR YEAR 2005

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2005	\$ 12,921,833.00	\$ 12,708,377.54	\$ 12,675,369.97	99.74%	\$ 33,007.57
2ND QTR. 2005	\$ 13,091,881.60	\$ 13,090,687.66	\$ 13,068,583.65	99.83%	\$ 22,104.01
3RD QTR. 2005	\$ 12,859,825.39	\$ 12,727,808.82	\$ 12,698,516.91	99.77%	\$ 29,291.91
4TH QTR. 2005	\$ 14,225,198.14	\$ 13,979,384.39	\$ 14,016,694.40	100.27%	\$ (37,310.01)
<b>TOTAL CAL. 2005</b>	<b>\$ 53,098,738.13</b>	<b>\$ 52,506,258.41</b>	<b>\$ 52,459,164.93</b>	<b>99.91%</b>	<b>\$ 47,093.48</b>

DEPOSITS BY QUARTERS

JUL/SEP 05	\$ 7,797,108.05
OCT/DEC 05	\$ 12,712,308.14
JAN/MAR 06	\$ 21,318,602.30
APR/JUN 06	\$ 12,205,505.44
<b>TOTAL</b>	<b>\$ 54,033,523.93</b>

\$ 278,056,025.32 \$ 277,760,678.47

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/05 \$ 295,346.85

CALENDAR YEAR 2006

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2006	\$ 10,484,109.48	\$ 7,979,592.29	\$ 7,920,387.32	99.26%	\$ 59,204.97
2ND QTR. 2006	\$ 8,998,625.14	\$ 8,958,134.82	\$ 8,942,911.21	99.83%	\$ 15,223.61
3RD QTR. 2006	\$ 7,933,305.79	\$ 7,933,255.15	\$ 7,936,665.09	100.04%	\$ (3,409.94)
4TH QTR. 2006	\$ 8,143,973.58	\$ 8,105,171.46	\$ 8,084,734.03	99.75%	\$ 20,437.43
<b>TOTAL CAL. 2006</b>	<b>\$ 35,560,013.99</b>	<b>\$ 32,976,153.72</b>	<b>\$ 32,884,697.65</b>	<b>99.72%</b>	<b>\$ 91,456.07</b>

\$ 311,032,179.04 \$ 310,645,376.12

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/06 \$ 386,802.92

DEPOSITS BY  
QUARTERS

JUL/SEP 06	\$ 8,831,191.71
OCT/DEC 06	\$ 2,052,755.91
JAN/MAR 07	\$ 10,774,044.27
APR/JUN 07	\$ 8,846,674.21
<b>TOTAL</b>	<b>\$ 30,504,666.10</b>

CALENDAR YEAR 2007

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2007	\$ 9,715,561.73	\$ 10,040,149.55	\$ 9,943,627.58	99.04%	\$ 96,521.97
2ND QTR. 2007	\$ 9,438,115.33	\$ 9,265,018.79	\$ 8,983,839.95	96.97%	\$ 281,178.84
3RD QTR. 2007	\$ 9,154,050.71	\$ 9,154,050.71		0.00%	\$ 9,154,050.71
4TH QTR. 2007				#DIV/0!	\$ -
<b>TOTAL CAL. 2007</b>	<b>\$ 28,307,727.77</b>	<b>\$ 28,459,219.05</b>	<b>\$ 18,927,467.53</b>	<b>66.51%</b>	<b>\$ 9,531,751.52</b>

\$ 339,491,398.09 \$ 329,572,843.65

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/07 \$ 9,918,554.44

DEPOSITS BY  
QUARTERS

JUL/SEP 07	\$ 12,064,788.85
OCT/DEC 07	\$ 1,454,643.11
JAN/MAR 08	
APR/JUN 08	
<b>TOTAL</b>	<b>\$ 13,519,431.96</b>

# ATTACHMENT 2

**Attachment 2**

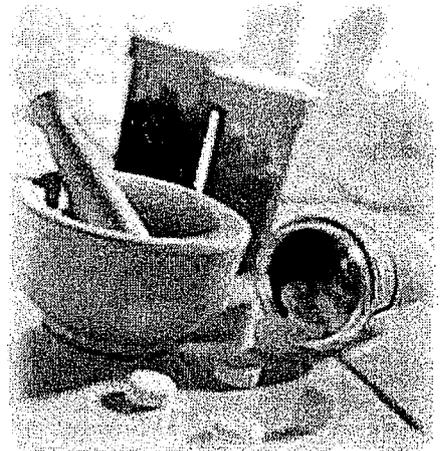


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# **ANNUAL REPORT**

**JULY 2006 to JUNE 2007**

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**The Utah Medicaid  
Drug Regimen Review Center  
421 Wakara Way, Suite 208  
Salt Lake City, UT 84108  
[www.utahdrrc.org](http://www.utahdrrc.org)**

The University of Utah College of Pharmacy began operating the Drug Regimen Review Center (DRRC) in May 2002 to fulfill the terms of a contract with Utah Medicaid. The contract supports the Utah Medicaid prescription drug program and its drug utilization review department. The emphasis of the program is to improve drug use in Medicaid patients, to reduce the number of prescriptions and drug cost in high utilizers of the Medicaid drug program, and to educate prescribers for top utilizers of the Utah Medicaid prescription drug program.

Each month, the top drug utilizers are reviewed by a team of clinically trained pharmacists. These reviews result in recommendations that are made to prescribers. These recommendations are described later in this report. Recommendations are transmitted in writing, are sent to all prescribers, and include a list of drugs dispensed during the month of review. The DRRC also provides information and consultation by telephone with prescribers and pharmacists.

## **Staff**

The DRRC utilizes a staff of professionals to run the program including:

### **Pharmacists**

Karen Gunning, Pharm.D.  
Mei Jen Ho, Pharm.D.  
Joanne LaFleur, Pharm.D.  
Bryan Larson, Pharm.D.  
CarrieAnn McBeth, Pharm.D.  
Janet Norman, R.Ph.  
Gary M. Oderda, Pharm.D., M.P.H.  
Lynda Oderda, Pharm.D.  
Marianne Paul, Pharm.D.  
Carin Steinvoot, Pharm.D.

### **Data Management**

Lisa Angelos  
Brian Oberg  
David Servatius  
Kami Doolittle  
Yi Wen Yao

## **Mission**

The mission of the DRRC is to review the drug therapy of Medicaid patients receiving more than seven prescriptions per month and to work with the individual prescribers to provide the safest and highest quality pharmacotherapy at the lowest cost possible.

## **Methodology**

DRRC program methodology continues with no change from previous reports.

We continue to build a cross-reference table of prescriber identification numbers, prescriber license numbers and DEA numbers that now contains 52,857 listings covering all known license addresses.

We continue to send letters to prescribers with recommendations for changes in drug therapy as appropriate. To date, we have mailed 33,841 of these letters to 7,317 different prescribers with recommendations concerning 9,292 Medicaid patients.

## **Overview**

Utah Medicaid drug claim costs had increased substantially over the past several years. The total increase in these costs from January 2002 to January 2006, when the Medicare Part D prescription drug benefit went into effect, had been approximately 75.8%. In January 2006 these costs dropped sharply and have been fluctuating but fairly level since that time. Recently, the total number of claims decreased slightly from 170,010 to 165,525 per month (2.5%) during the period from July 2006 to June 2007, while drug costs increased slightly from \$10,973,133 to \$11,036,414 per month (1.3%) during this same period.

Figures 1 and 2 show the total number of Medicaid pharmacy claims and the total cost of these claims for each month during the reporting period from July 2006 to June 2007, and Figure 3 shows the trend in total drug claim costs during the entire project period from January 2002 to June 2007.

Figure 1 – Total Medicaid Drug Claims by Month from July 2006 to June 2007

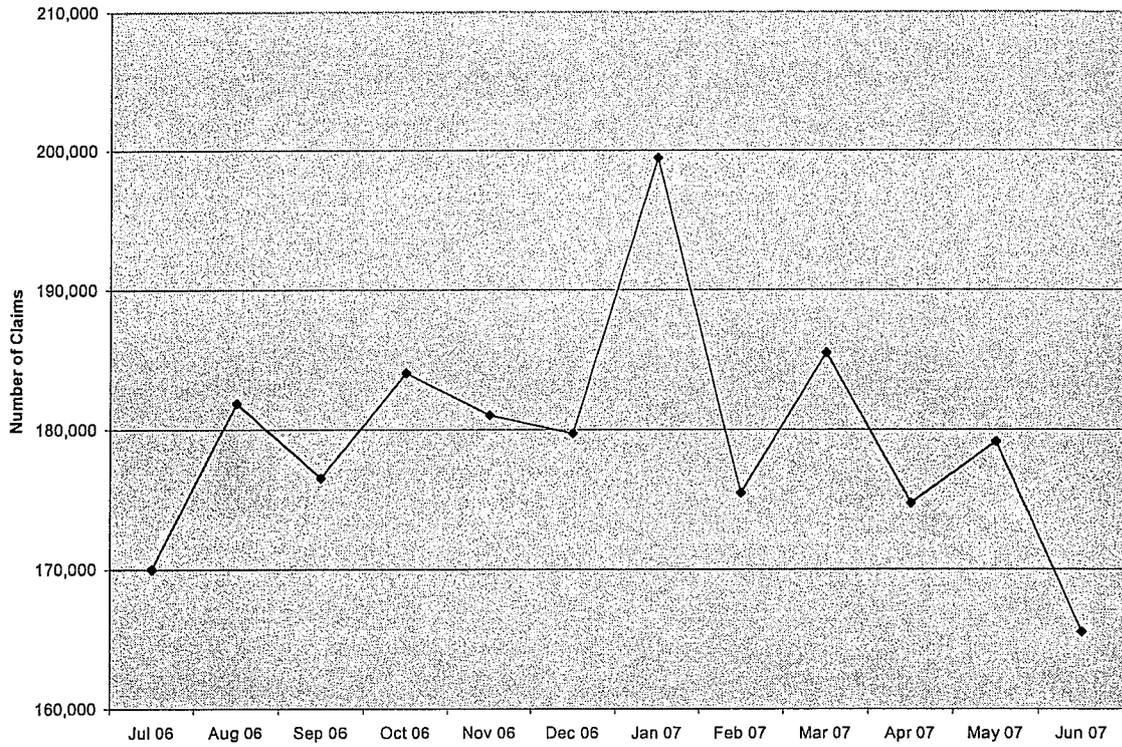
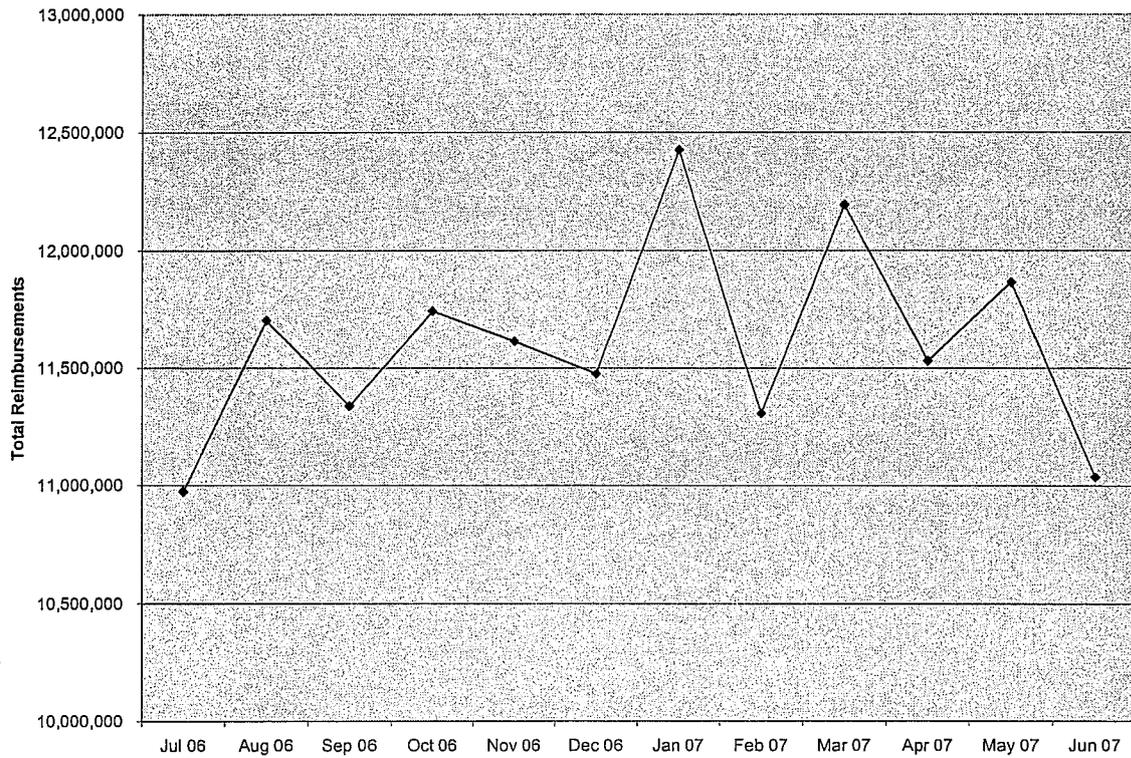
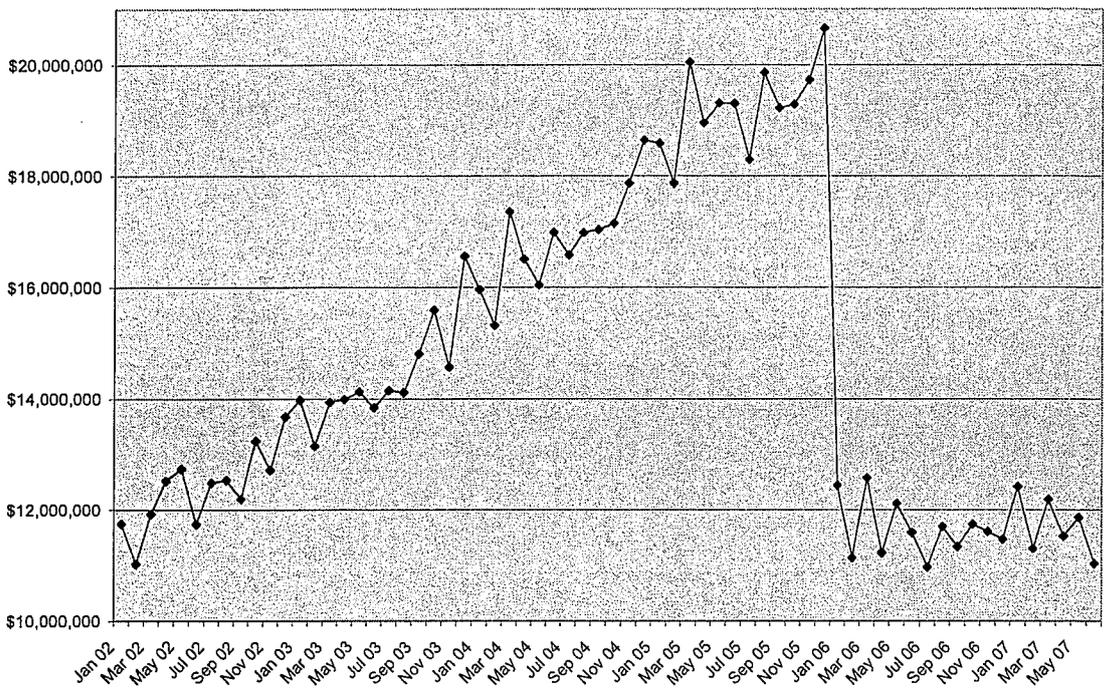


Figure 2 – Total Medicaid Drug Claim Costs by Month from July 2006 to June 2007



**Figure 3 – Total Medicaid Drug Program Costs from January 2002 to June 2007**

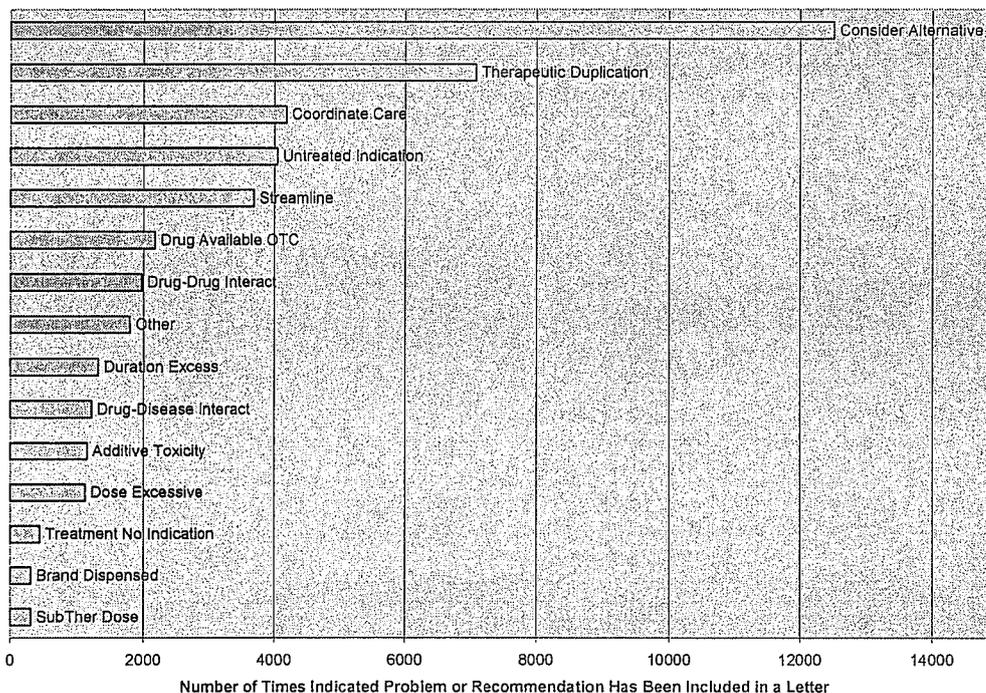


Additional figures for each fiscal year from 2001 to present are included in **Appendix A**. Increases for the previous three fiscal years were 16.4% (July 2004 to June 2005), 13.1% (July 2005 to January 2006 – when Medicare Part D went into effect), and recently only 1.3% (July 2006 to June 2007).

**Program Summary**

Figure 4 summarizes the drug related problems identified in the letters that have been sent to prescribers.

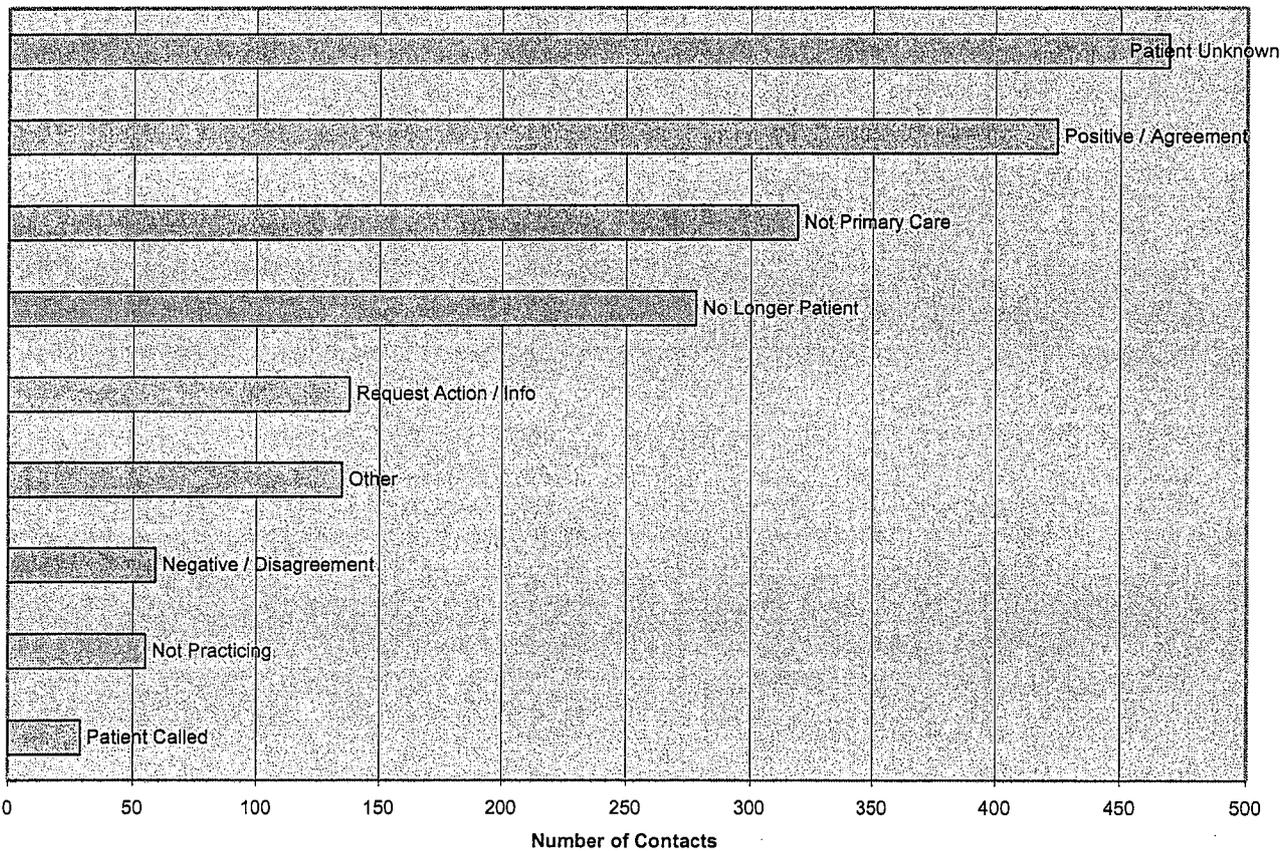
**Figure 4 – Type of Drug Related Problems and Recommendations in Letters Sent to Prescribers**



Recommendation categories outlined above are self-explanatory, although the top categories do deserve further description. The most common recommendation was for the prescriber to consider alternative therapy. This recommendation would have been made for a number of reasons, including considering a less costly alternative. Therapeutic duplication recommendations were made when the patient was taking multiple therapeutic agents for the same indication when there was generally no reason to include therapy with more than one agent. Coordinate care relates to situations where it appeared that multiple prescribers were ordering therapy for what appeared to be the same illness, and untreated indication recommendations were made if there was an absence of a medication that appeared to be needed based on usual best practice or guidelines. Streamline therapy refers to considering changes in therapy to eliminate some of the drugs dispensed.

Figure 5 summarizes the responses of the 1,907 individuals who contacted the DRRC after receipt of a letter.

**Figure 5 – Types of Prescriber Responses to Letters Received**



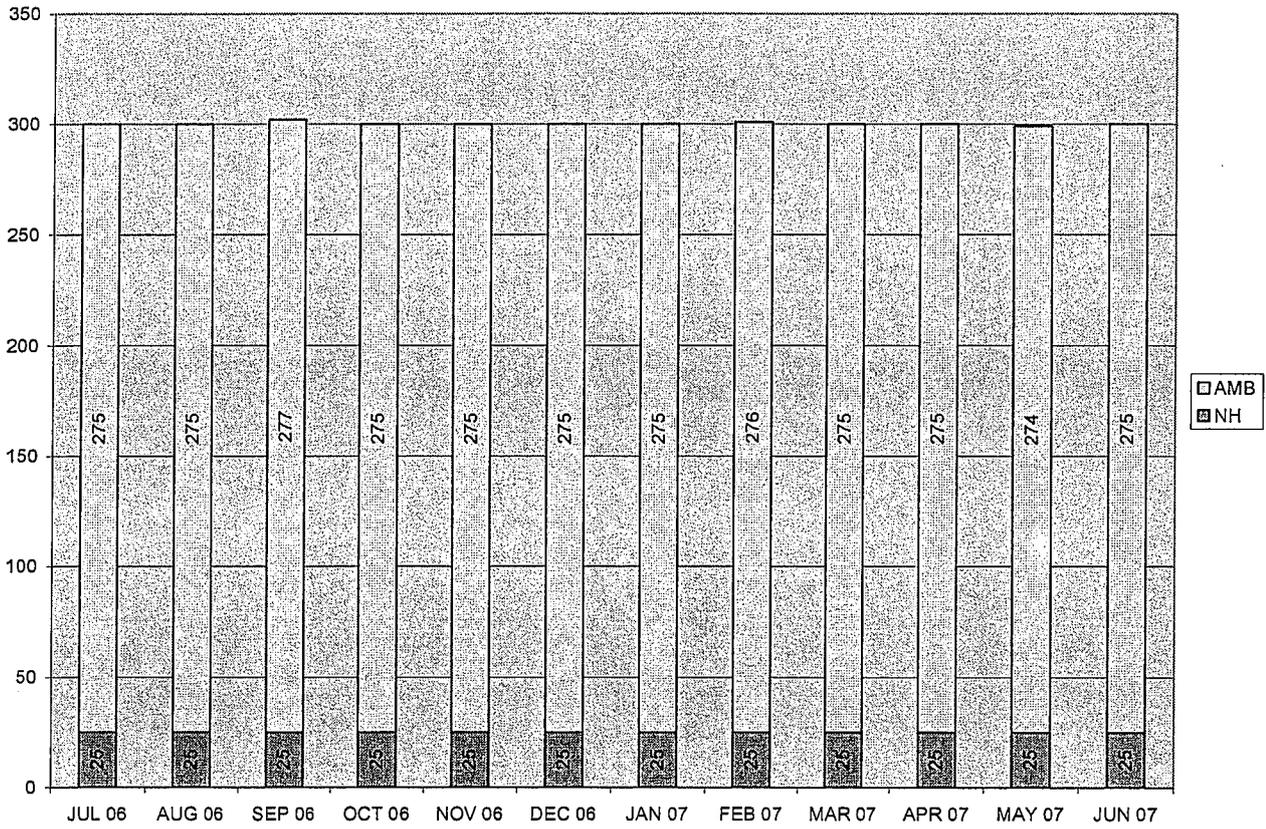
We have received a variety of comments from the prescribers, including both agreement with recommendations and some disagreement. We have also encountered some administrative problems such as pharmacy input error, incorrect addresses on file, and patients not being treated by the prescriber identified. As a result of verification procedures we have implemented, the incidence of these types of problems has gone down dramatically since the beginning of the program.

**Demographics**

The 3,602 patients reviewed from July 2006 to June 2007 were separated into cohorts based on the month they were reviewed.

Figure 6 summarizes the number of patients reviewed each month during this period, with the numbers of nursing home and ambulatory patients separated. The average was 300 patients per month and 25 of the reviewed patients each month were nursing home patients.

**Figure 6 – Summary of Nursing Home (NH) and Ambulatory (AMB) Patients Reviewed Each Month from July 2006 to June 2007**



Demographics for these cohorts are displayed in Table 1 and include gender, average age, and the average number of prescriptions dispensed. Nursing home patients are not included in this table.

**Table 1 – Cohort Demographics**

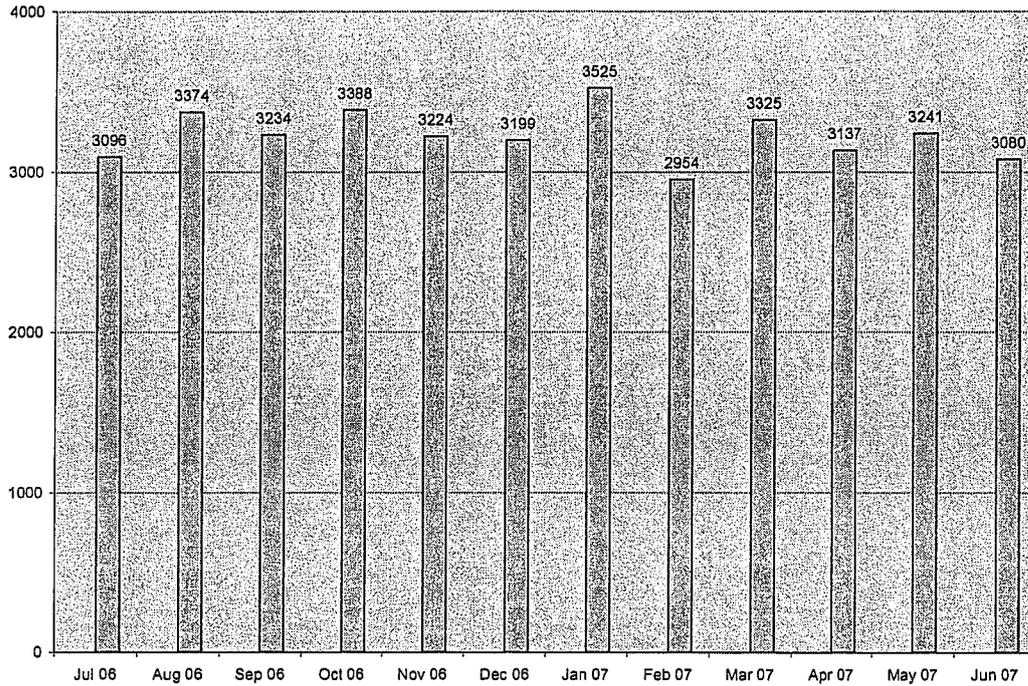
MONTH	Patients							
	Females				Males			
	Percent	Mean Age	Mean # Rx	Mean Cost Per RX	Percent	Mean Age	Mean # Rx	Mean Cost Per RX
Jul 06	76.8	44.5	12.5	\$68.59	23.2	46.4	12.9	\$86.56
Aug 06	80.0	43.2	13.7	\$63.71	20.0	49.6	14.7	\$85.04
Sep 06	74.7	44.3	12.5	\$68.54	25.3	44.8	12.6	\$83.48
Oct 06	82.2	43.3	13.6	\$63.14	17.8	43.9	13.1	\$107.68
Nov 06	69.5	41.4	11.6	\$61.37	30.5	41.8	11.8	\$83.95
Dec 06	80.4	44.4	11.8	\$71.53	19.6	45.8	11.5	\$79.04
Jan 07	74.9	44.7	13.1	\$66.08	25.1	44.4	13.4	\$78.54
Feb 07	75.7	46.1	12.1	\$69.95	24.3	43.5	11.7	\$92.48
Mar 07	76.4	42.3	11.5	\$70.74	23.6	46.7	11.4	\$75.94
Apr 07	73.5	43.0	12.3	\$70.82	26.5	44.2	12.8	\$85.15
May 07	77.3	45.6	13.3	\$73.80	22.7	45.9	13.0	\$80.25
Jun 07	78.1	44.7	11.8	\$70.07	21.9	46.6	12.1	\$89.95

Reviewed ambulatory patients during the reporting period were predominantly females in their 40s who filled on average between eleven and fourteen prescriptions per month.

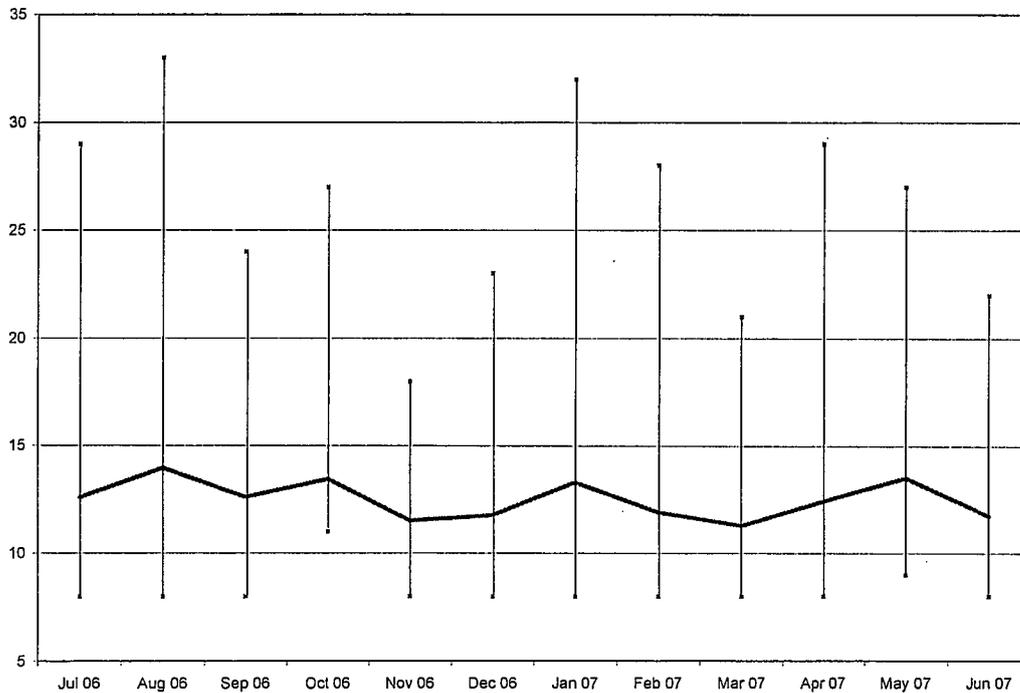
## Program Trends

The following figures show the number of patients exceeding seven prescriptions per month, and the average and range of the number of prescriptions for the reviewed cohorts. Slightly more than 3,000 patients each month exceeded seven prescriptions. The mean number of prescriptions that triggered review generally ranged from 12 to 14 while the maximum number of prescriptions for a reviewed patient exceeded 30.

**Figure 7 – Total Number of Ambulatory Medicaid Patients Exceeding Seven Prescriptions per Month between July 2006 and June 2007**



**Figure 8 – Average Number of Prescriptions per Month per Reviewed Ambulatory Medicaid Patient, including Minimum and Maximum Number of Prescriptions per Review Group**



## Program Effectiveness

The DRRC's two major goals are to improve pharmacotherapy for Medicaid patients and to reduce health care costs by decreasing the number of prescriptions and prescription cost. As the review process has matured, we have increased the number of telephone calls to providers to discuss drug related problems. Because of that, we have more information on the impact of our reviews.

The following three patient presentations describe representative examples of the types of patients being reviewed, and the outcome of those reviews:

### PATIENT 1

The medication regimen of a 26-year-old female was reviewed for the month of October 2006. During the month of review, the patient filled prescriptions for twenty different medications from fifteen different doctors. Included in the patient's prescriptions for the month were five different courses of antibiotics filled at five different pharmacies. There were also multiple prescription fills for opiate analgesics from eight different doctors. As such a prescription profile is often an indication of attempts to acquire excessive amounts of opiate medications, this patient was referred to the Medicaid restriction program so that she could be assigned to one primary-care provider to closely monitor her medication regimen. The patient also received a prescription for ibuprofen, an NSAID, despite having a diagnosis and receiving ongoing treatment for inflammatory bowel disease (IBD). NSAID therapy is not generally recommended during flare-ups of IBD, as it may increase the risk of gastrointestinal bleeding. This potential was described in the letter, since the NSAID was prescribed by a different doctor than the patient's IBD therapy. Finally, the patient's records showed that she had been receiving Aciphex, a proton-pump inhibitor (PPI). A recommendation was made to change her PPI therapy to Prilosec OTC, if appropriate, since Prilosec OTC is as effective but much less costly than Aciphex.

### PATIENT 2

The medication regimen of a 50-year-old female was reviewed for the month of June 2007. She received fourteen different prescriptions during the month at a total cost of \$1,373. Several drug-related problems were identified and addressed in a letter to her doctor. This patient had been receiving two SSRI antidepressants, Lexapro and fluoxetine. It was recommended that she be stabilized on only one SSRI antidepressant. The Lexapro dose exceeded the maximum recommended daily dose so it was therefore recommended that the dose be decreased if she continued on Lexapro. Additionally, she had been receiving fluoxetine 80 mg daily dosed as two 40 mg capsules. 40 mg capsules are much more expensive per unit compared with 20 mg capsules. It was recommended that she be stabilized on 20 mg capsules if she continued on fluoxetine which would save approximately \$180 monthly. Significant drug interactions were also identified. She had been receiving both fluoxetine and amitriptyline at high doses. This combination may result in amitriptyline toxicity through inhibition of cytochrome p450 enzymes by fluoxetine. Fluoxetine has been found to increase serum amitriptyline levels 100% to 800%. It was recommended that this patient be evaluated for amitriptyline toxicity and that the dose of amitriptyline be lowered if necessary. She also had been receiving multiple medications that may prolong the QT interval (Geodon, fluoxetine, amitriptyline). It was advised that combining such medications may result in adverse cardiac effects. Finally, this patient had been receiving Nexium. A change was recommended to a less costly but equally effective alternative, Prilosec OTC. This change would result in cost savings of approximately \$100 monthly.

### PATIENT 3

A 47-year-old female was reviewed in December 2006. At that time she received 26 medications from seven physicians at a cost of \$3,237.47 for the month. Nine issues were identified by the pharmacist and a letter was sent to the physicians. Among these issues were two therapeutic duplications of medications, four possible drug-drug interactions and two suggested therapeutic drug substitutions. In July 2007 this same patient's profile showed just sixteen drugs at a monthly cost of \$1,153.73 from four doctors. More importantly, the drugs responsible for most of the drug-drug interactions had been discontinued, decreasing the overall risk to this patient of having an adverse drug reaction. Of the initial nine issues originally identified, five have been addressed and resolved.

### 90-Day Tracking of Top Ten Reviewed Utilizers per Month

We have also tracked the top ten reviewed utilizers of the Medicaid prescription drug benefit for 90 days following the mailing of the recommendation letters to prescribers. We compared each patient's total drug fills, total costs and total drug related problems identified in the letters at the time of review and then again after 90 days. In all instances so far we have seen substantial to dramatic decreases in all three categories.

**Table 2 – 90 Day Tracking of Top Ten Reviewed Utilizers per Month**

	Drug Fills			Costs			Drug Related Problems			Demographics		
	Initial	Track	Change	Initial	Track	Change	Initial	Track	Change	M	F	Mean Age
Jan-06	20.6	17.3	-16.0%	1506.04	1329.99	-12.5%	41	26	-36.0%	29%	71%	37.4
Feb-06	19.6	8.3	-57.0%	1095.09	453.24	-58.0%	34	11	-68.0%	29%	71%	51.4
Mar-06	23.1	19.1	-17.0%	1488.21	1282.35	-14.0%	57	30	-47.0%	14%	86%	50.1
Apr-06	22.9	22.8	-0.5%	1882.38	1752.38	-7.0%	42	28	-33.3%	11%	89%	46.9
May-06	22.0	14.1	-35.9%	1840.66	1236.66	-32.8%	41	21	-48.8%	0%	100%	51.8
Jun-06	23.0	15.9	-30.9%	1313.76	1154.24	-12.1%	55	30	-45.5%	44%	56%	46.4
Jul-06	21.1	16.0	-24.2%	1376.50	1291.93	-6.1%	44	27	-38.6%	44%	56%	40.9
Aug-06	28.0	27.3	-2.6%	2177.51	1995.31	-8.4%	64	43	-33.1%	25%	75%	53.3
Sep-06	21.3	12.3	-42.3%	1365.90	888.60	-34.9%	61	22	-63.9%	20%	80%	47.2
Oct-06	20.8	17.0	-18.3%	1513.95	1335.69	-11.8%	63	34	-46.0%	0%	100%	50.5
Nov-06	16.8	10.3	-38.7%	1885.96	1426.36	-24.4%	20	12	-40.0%	33%	67%	41.7
Dec-06	20.2	11.4	-43.6%	1424.56	864.27	-39.3%	64	24	-62.5%	20%	80%	49.1
<b>2006</b>	<b>21.7</b>	<b>15.9</b>	<b>-26.7%</b>	<b>1554.39</b>	<b>1246.94</b>	<b>-19.8%</b>	<b>592</b>	<b>314</b>	<b>-47.0%</b>			

**Figure 9 – Summary of Results: 90-Day Tracking of Top Ten Reviewed Utilizers per Month**

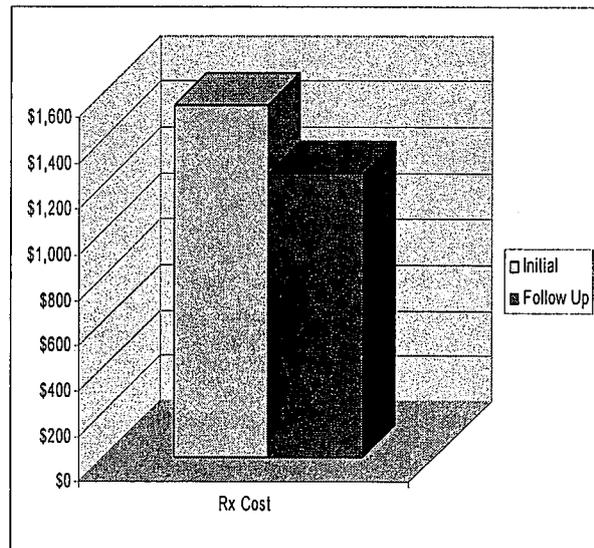
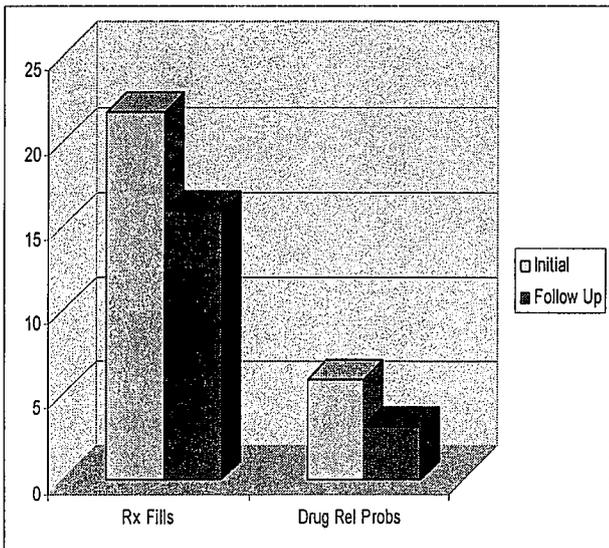
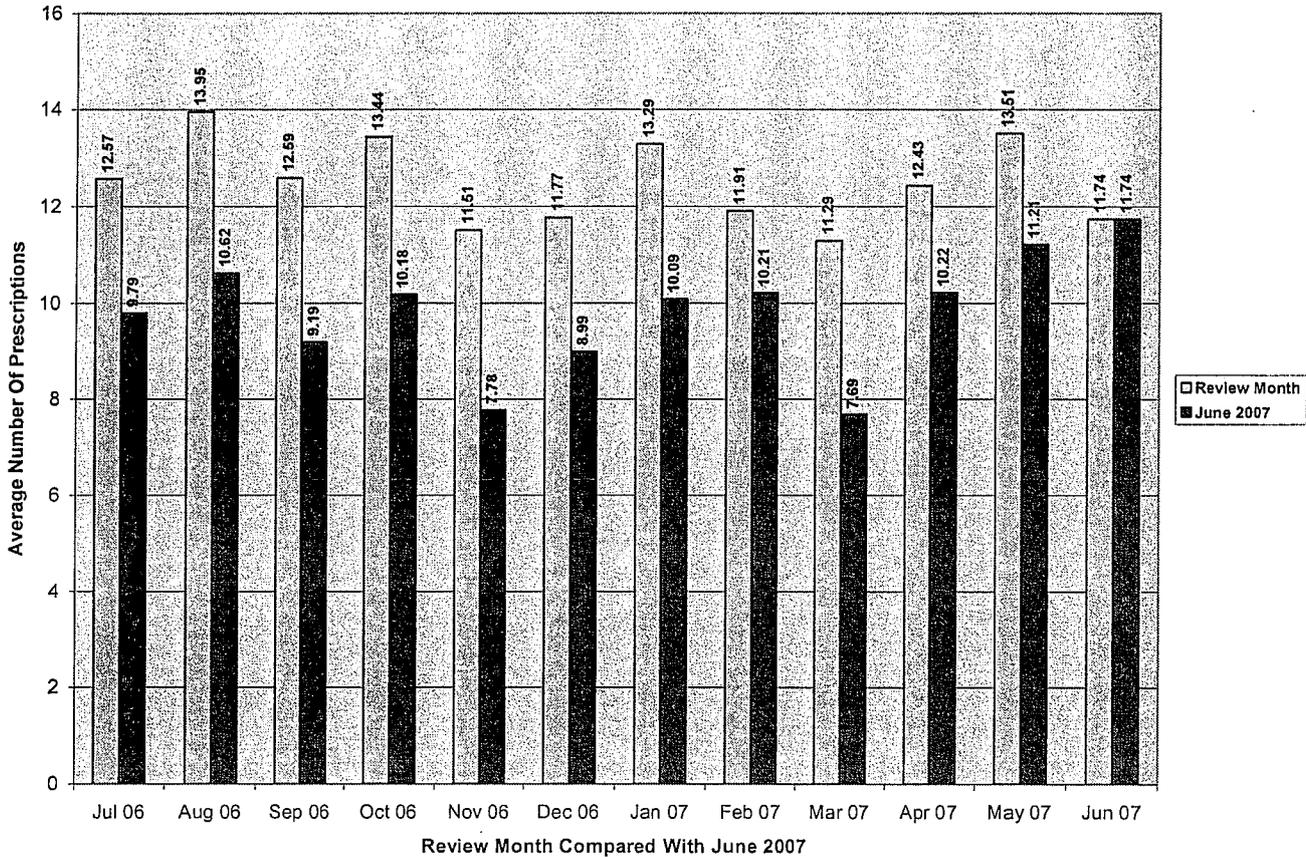


Figure 10 shows the average number of prescriptions per reviewed patient for each month from July 2006 to June 2007, compared to the average number of prescriptions per patient for the same cohort in June 2007. The average number of prescriptions per reviewed patient has decreased over the course of the year from 12.57 to 11.74 prescriptions per month. The number of prescriptions dispensed has decreased for all review cohorts. No change was seen for June 2007 since this report only covers data through June 2007.

**Figure 10 – Average Prescriptions for Reviewed Cohort in Review Month and Compared to June 2007**



We have tracked drug cost reimbursements to review cohorts for the remainder of the reporting year following the month they were reviewed. We have only tracked costs for patients within each review cohort who remained eligible during the entire reporting period and accessed their drug benefit at least one time during each of the 12 months in the reporting period. Decreases in drug costs for these selected patients were substantial.

The review month was used as the baseline amount for comparison. Costs were compared for the baseline amount with the amount for June 2007. For example, costs in June 2007 and October 2006 were compared for patients reviewed during October 2006. Cost savings were calculated only for patients reviewed from July 2006 to June 2007. Additional cost savings for patients reviewed before July 2006 are not included, nor are additional savings that would be expected after June 2007 for patients included in this report. We have assumed that drug costs would remain constant since the month of review. Given this assumption costs decreased by \$2,441,672.

In considering this information it is important to understand that we cannot determine what the reviewed patients' drug costs would have been if they had not been reviewed. It is possible that without a review their costs would have increased, remained the same or declined. To effectively address this we would need to compare changes in prescription drug costs over the same period with a suitable control group. This is not possible with our current patient selection process but will be done as part of a Medicaid transformation grant project currently underway.

Cost calculations are detailed on the following page in Table 3.

Table 3 - Costs

TOTAL FOR ALL REVIEWED PATIENTS ELIGIBLE AND UTILIZING RX BENEFITS ENTIRE REPORTING PERIOD - NO INCREASE IN COSTS ASSUMED

	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	TOTAL PROJECTED	SAVINGS	
Jul 06	224,255	194,741	179,693	183,709	174,356	162,850	189,536	150,686	187,246	170,351	183,038	176,581	2,177,043	2,691,059	514,016
Aug 06		211,002	178,880	183,179	160,241	175,829	182,157	165,464	182,166	171,166	171,902	182,532	1,964,517	2,321,018	356,501
Sep 06			192,555	173,204	153,797	151,086	159,598	156,506	159,464	161,860	169,745	161,491	1,639,306	1,925,545	286,240
Oct 06				236,180	185,383	191,260	198,638	188,706	183,797	192,994	191,482	194,512	1,762,951	2,125,619	362,668
Nov 06					164,765	130,711	139,602	128,984	130,675	122,252	129,318	126,612	1,072,920	1,318,121	245,201
Dec 06						184,055	165,361	148,805	149,973	149,519	147,165	147,165	1,092,042	1,288,382	196,340
Jan 07							203,977	159,794	173,600	173,471	160,614	170,942	1,042,398	1,223,865	181,467
Feb 07								215,205	201,655	185,670	183,066	185,209	970,805	1,076,026	105,221
Mar 07									168,686	131,294	141,333	133,032	574,346	674,743	100,398
Apr 07										227,374	209,606	201,332	638,313	682,122	43,810
May 07											233,015	183,205	416,220	466,030	49,810
Jun 07												227,519			
													13,350,858	15,792,530	2,441,672

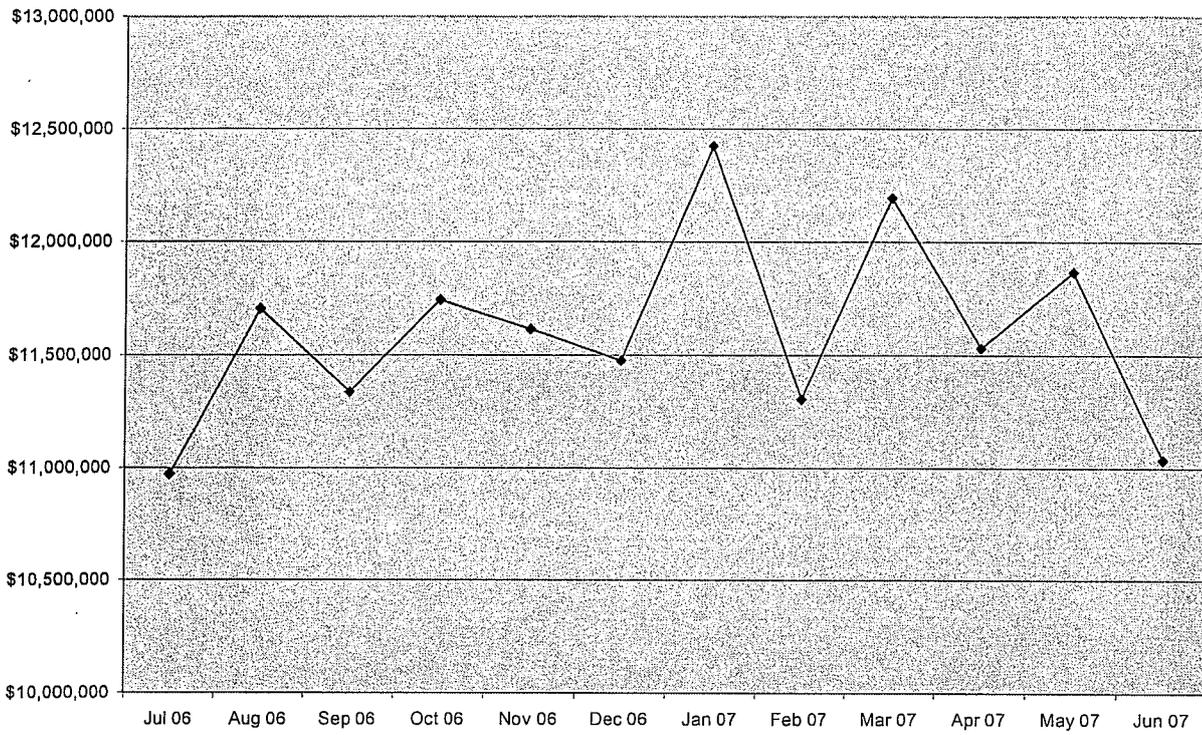
PATIENTS 203 197 216 214 187 192 197 220 191 202 198 231  
 \*Total number from each monthly review cohort remaining eligible for AND utilizing prescription drug benefits during the entire 12-month reporting period.

AVERAGE PER PATIENT

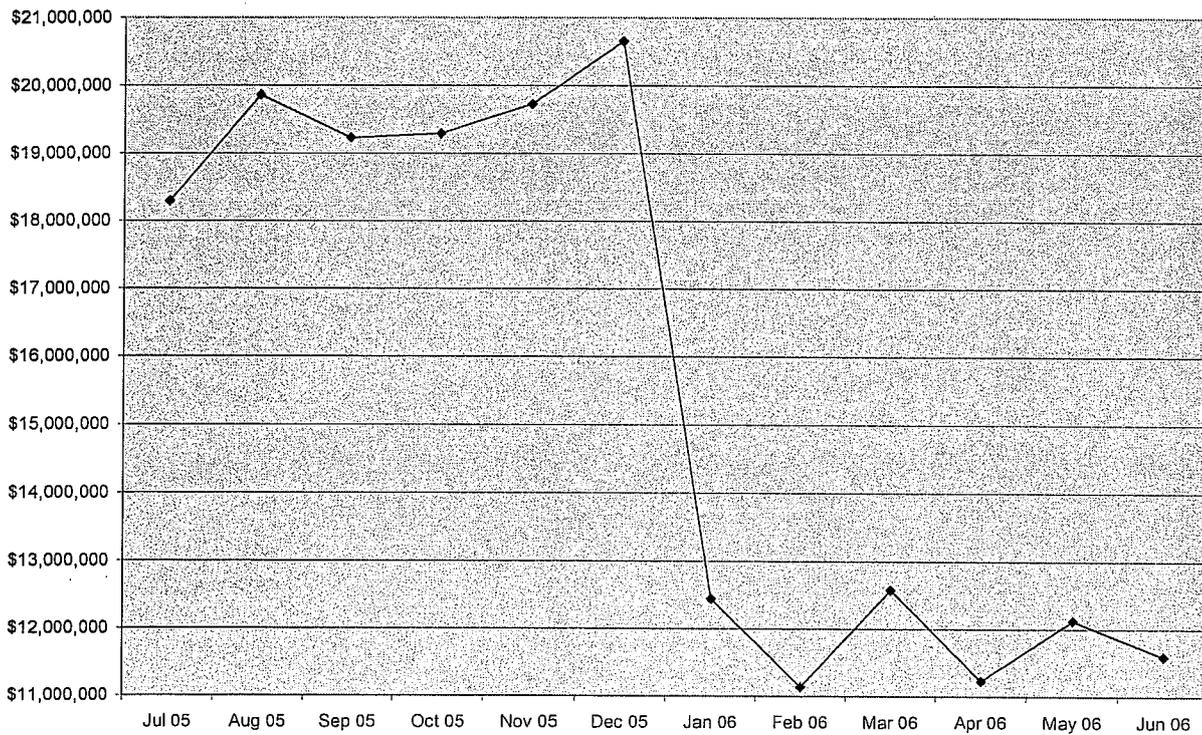
	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	TOTAL PROJECTED	SAVINGS	
Jul 06	1,105	959	885	905	859	802	934	742	922	839	902	870	10,724	13,256	2,532
Aug 06		1,071	908	930	813	893	925	840	925	869	873	927	9,972	11,782	1,810
Sep 06			891	802	712	699	739	725	738	749	786	748	7,589	8,915	1,325
Oct 06				1,104	866	894	928	882	859	902	895	909	8,238	9,933	1,695
Nov 06					881	699	747	690	699	654	692	677	5,738	7,049	1,311
Dec 06						959	861	775	781	779	766	766	5,688	6,710	1,023
Jan 07							1,035	811	881	881	815	868	5,291	6,213	921
Feb 07								978	917	844	832	842	4,413	4,891	478
Mar 07									883	687	740	697	3,007	3,533	526
Apr 07										1,126	1,038	997	3,160	3,377	217
May 07											1,177	925	2,102	2,354	252
Jun 07												985			
													65,922	78,011	12,089

# **APPENDIX A**

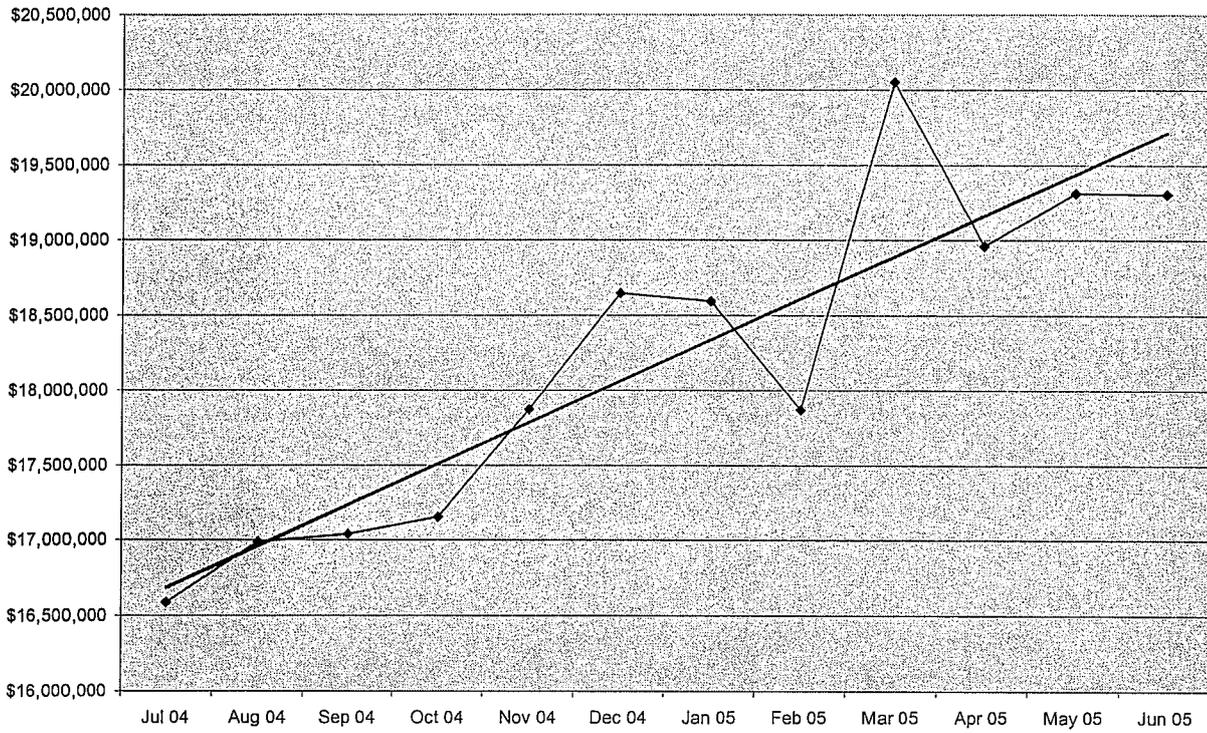
JULY 06 to JUNE 07



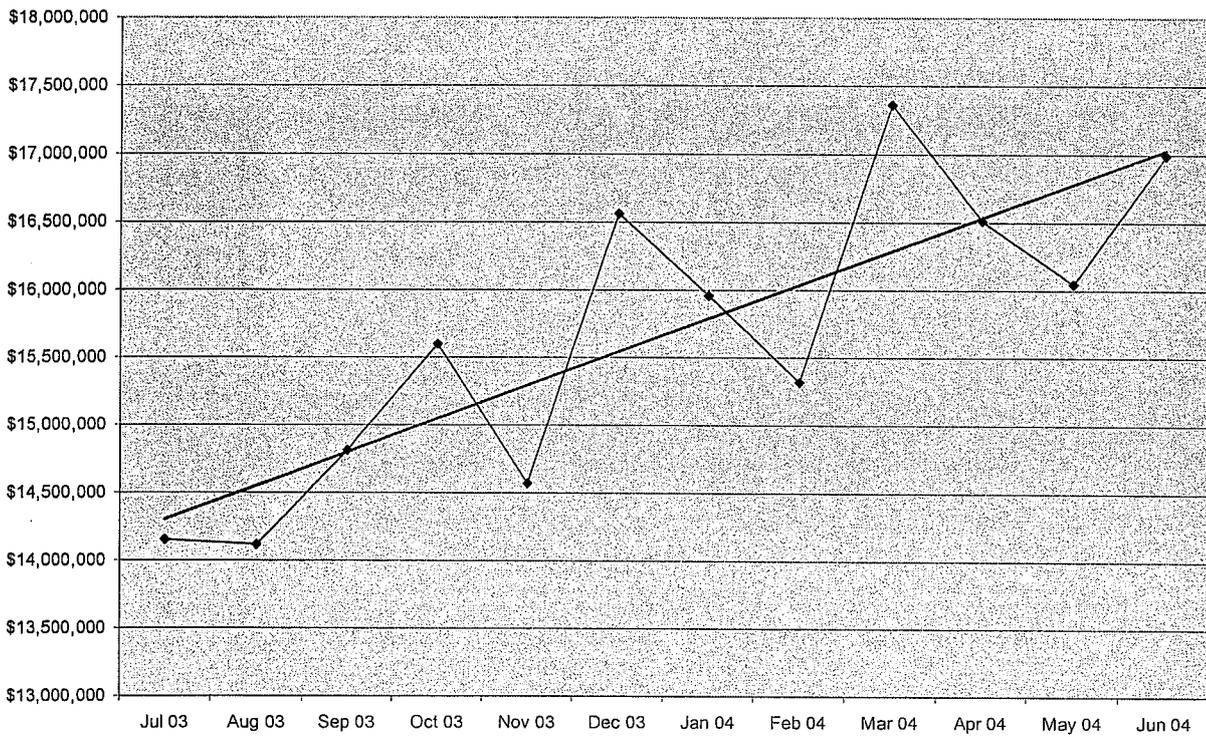
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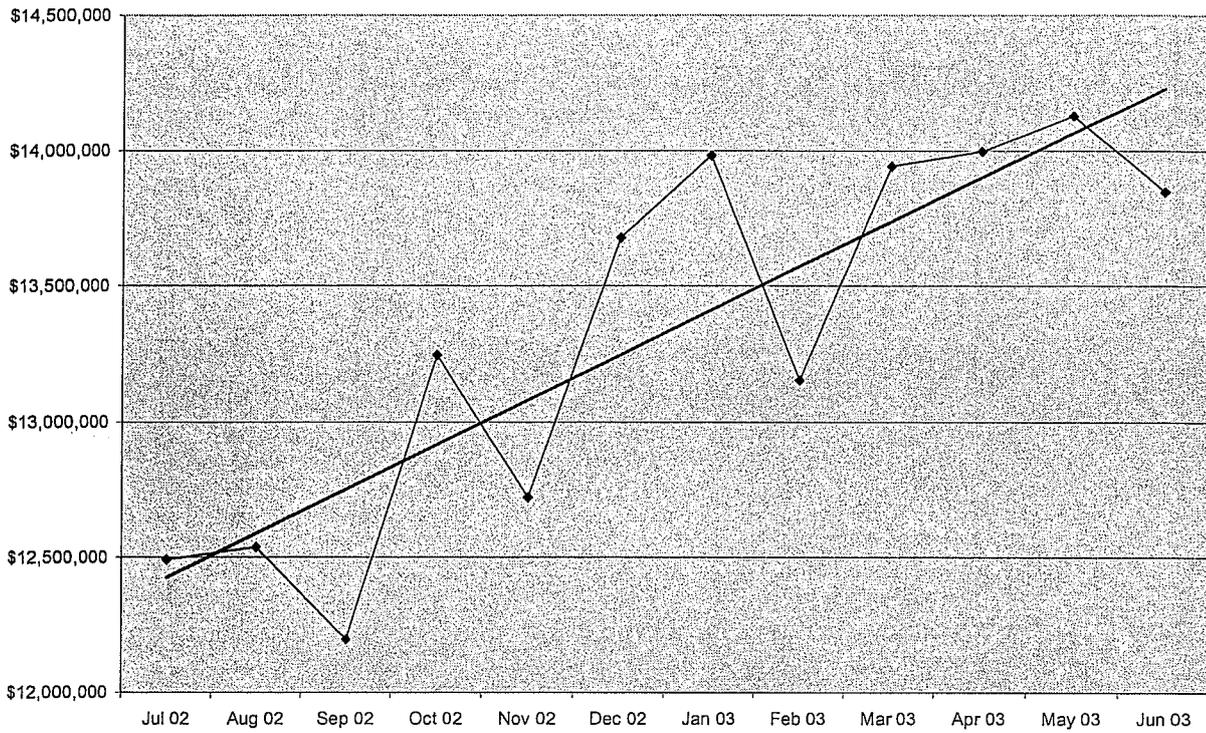
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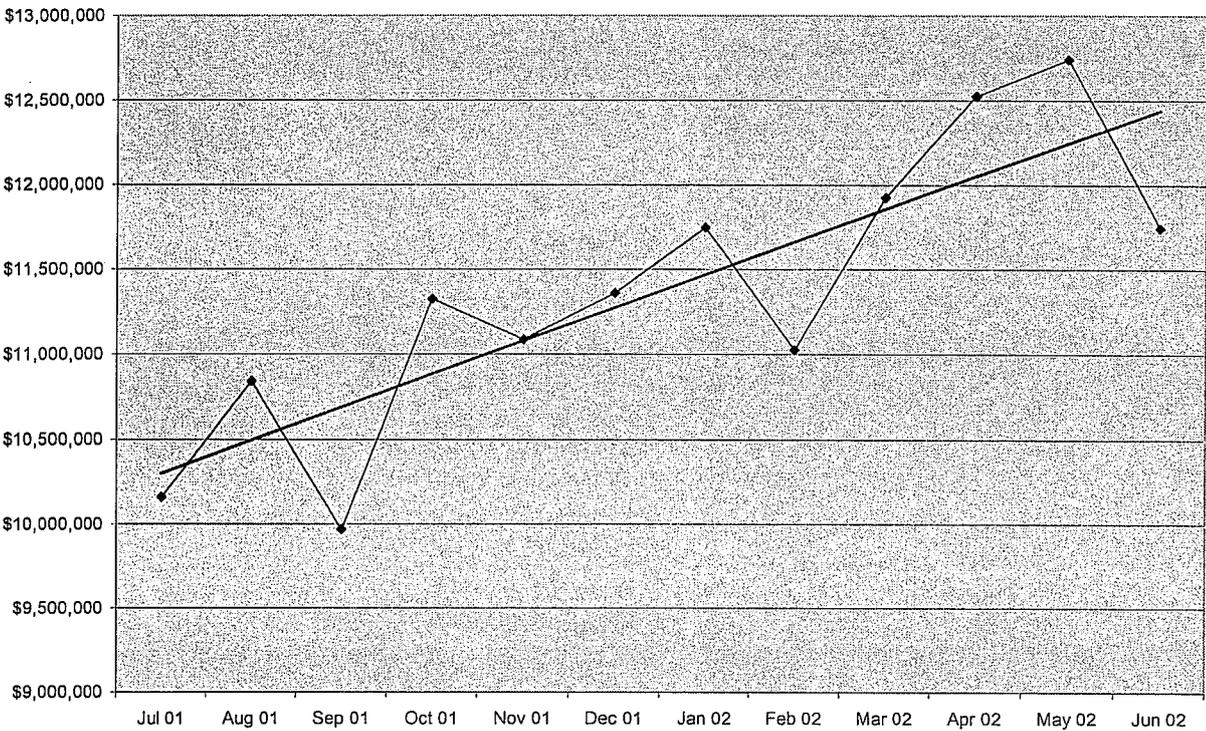
JULY 03 to JUNE 04



**JULY 02 to JUNE 03**



**JULY 01 to JUNE 02**



# ATTACHMENT 3



ATTACHMENT 3-1

Utah  
Targeted Child Patient Report by Quality Indicator  
Child Interventions January 2006 - September 2006

Quality Indicator	Total Patients Targeted Prior to this Meeting	Average Number of Days Targeted for QI	Number No Longer Targeted for QI	Number Still Targeted for QI	Number No Longer Targeted for QI	Number Newly Targeted this Month	Percent Change
Use of Benzodiazepines for 60 or More Days (Under 18 Years)	127	75	84	43	73	25	66%
Use of Opiates for 45 or More Days (Under 18 Years)	20	41	16	4	14	0	80%
Use of 2 or More Atypicals and a Stimulant or ADHD Non-Stimulant for 30 or More Days (Under 18 Years)	67	76	39	28	38	8	58%
Use of 2 or More SSRIs for 60 or More Days (Under 18 Years)	1	30	1	0	1	0	100%
Use of 3 or More Psychotropics for 90 or More Days (6-12 Years)	128	67	86	42	83	27	67%
Use of 4 or More Psychotropics for 90 or More Days (6-12 Years)	28	63	23	5	23	8	82%
Use of 3 or More Psychotropics for 90 or More Days (Under 6 Years)	1	0	0	1	0	3	0%
Use of 2 or More Antipsychotics for 45 or More Days (Under 18 Years)	157	75	80	77	71	21	51%
Multiple Prescribers of Any Psychotropic Drug for 45 or More Days (Under 18 Years)	432	61	329	103	329	85	76%
Overall Unique Count of Patients	730		481	249	442	159	

Note: Numbers exclude patients hitting these indicators for the first time this month

## ATTACHMENT 3-2

Utah  
Targeted Child Prescriber Change Report by Quality Indicator  
Child Interventions January 2006 - September 2006

Quality Indicator	Total Prescribers Targeted Prior to this Month	Average Number of Days Targeted for QI	Number No Longer Targeted for QI	Number Still Targeted for QI	Number No Longer Targeted for QI	Number Newly Targeted this Month	Percent Change	Percent Change with Newly Targeted
Use of Benzodiazepines for 60 or More Days (Under 18 Years)	78	73	52	26	52	11	67%	58
Use of Opiates for 45 or More Days (Under 18 Years)	18	41	16	2	16	0	89%	89
Use of 2 or More Atypicals and a Stimulant or ADHD Non-Stimulant for 30 or More Days (Under 18 Years)	31	108	16	15	16	1	52%	50
Use of 2 or More SSRIs for 60 or More Days (Under 18 Years)	1	30	1	0	1	0	100%	100
Use of 3 or More Psychotropics for 90 or More Days (6-12 Years)	42	68	25	17	25	8	60%	50
Use of 4 or More Psychotropics for 90 or More Days (6-12 Years)	8	42	5	3	5	3	61%	45
Use of 3 or More Psychotropics for 90 or More Days (Under 6 Years)	1	0	0	1	0	0	0%	0
Use of 2 or More Antipsychotics for 45 or More Days (Under 18 Years)	42	104	21	21	21	2	50%	48
Multiple Prescribers of Any Psychotropic Drug for 45 or More Days (Under 18 Years)	399	76	271	128	271	45	68%	61
Overall Unique Count of Prescribers	426		281	145	328	66		

Note: Numbers exclude DNS prescribers who receive no mailings and prescribers hitting these indicators for the first time this month

Utah

Targeted Adult Patient Report by Quality Indicator  
Adult Interventions February, 2006 - August, 2006

Quality Indicator	Total Patients Targeted Prior to this Meeting	Average Number of Days Targeted for QI	Number No Longer Targeted for QI	Number Still Targeted for QI	Number No Longer Targeted for QI	Number Newly Targeted this Month	Percent Change
Use of 2 or More Benzodiazepines for 60 or More Days	101	46	75	26	68	10	74%
Use of 3 or More Opiates for 60 or More Days	8	47	7	1	7	2	88%
Use of 2 or More SSRIs for 60 or More Days	11	47	7	4	7	1	64%
Use of an ADHD Non-Stimulant and 1 or More Stimulants for 60 or More Days	2	59	2	0	2	0	100%
Use of 3 or More Antidepressants for 60 or More Days	15	43	9	6	9	1	60%
Use of 2 or More Antipsychotics for 60 or More Days	381	62	219	162	193	39	57%
Use of 5 or More Psychotropics for 60 or More Days	307	60	186	121	165	35	61%
Use of 2 or More Insomnia Agents for 60 or More Days	273	55	169	104	154	24	62%
Multiple Prescribers of Any Antipsychotic for 45 Days or More	74	54	44	30	41	19	59%
Multiple Prescribers of the Same Class of Psychotropic Drug for 45 or More Days	79	45	56	23	54	13	71%
Multiple Prescribers of 1 or More Opiates for 30 or More Days	323	51	232	93	229	73	71%
Use of an Atypical Antipsychotic at a Higher Than Recommended Dose for 45 or More Days	224	39	190	34	190	61	85%
Use of 2 or More Atypicals Both at a Lower Than Recommended Dose for 60 or More Days	232	57	133	99	124	27	57%
Overall Unique Count of Patients	3	70	3	0	3	0	100%
	1246		814	432	746	246	

Note: Numbers exclude patients hitting these indicators for the first three data months.

Utah  
 Targeted Adult Prescriber Change Report by Quality Indicator  
 Adult Interventions February, 2006 - August, 2006

Quality Indicator	Total Prescribers Targeted Prior to this Mailing	Average Number of Days Targeted for QI	Number No Longer Targeted for QI	Number Still Targeted for QI	Number No Longer Flagged for QI	Number Newly Targeted this Month	Percent Change
Use of 2 or More Benzodiazepines for 60 or More Days	56	50	41	15	41	7	73%
Use of 3 or More Opiates for 60 or More Days	7	50	6	1	6	2	86%
Use of 2 or More SSRIs for 60 or More Days	11	47	7	4	7	1	64%
Use of an ADHD Non-Stimulant and 1 or More Stimulants for 60 or More Days	2	59	2	0	2	0	100%
Use of 3 or More Antidepressants for 60 or More Days	14	60	8	6	8	1	57%
Use of 2 or More Atypical Antipsychotics for 60 or More Days	89	64	36	53	36	6	40%
Use of 5 or More Atypical Antipsychotics for 60 or More Days	79	60	33	46	33	6	42%
Use of 2 or More Insomnia Agents for 60 or More Days	92	60	43	49	43	7	47%
Multiple Prescribers of Any Antipsychotic for 45 Days or More	45	56	23	22	23	11	51%
Multiple Prescribers of the Same Class of Psychotropic Drug for 45 or More Days	79	47	49	30	49	10	62%
Multiple Prescribers of 1 or More Opiates for 30 or More Days	430	53	291	139	291	67	68%
Use of an Atypical Antipsychotic at a Higher Than Recommended Dose for 45 or More Days	386	49	296	90	296	66	77%
Use of 2 or More Atypicals Both at a Lower Than Recommended Dose for 60 or More Days	86	84	31	55	31	9	36%
Overall Unique Count of Prescribers	3	70	3	0	3	0	100%
	777		513	264	618	175	

Note: Numbers exclude DNS prescribers who receive no mailings and prescribers hitting these indicators for the first time this month