New Jersey Drug Utilization Review Board
Annual Report

July 1, 2011 through June 30, 2012

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I. Acknowledgements

The Prospective Drug Utilization Review (PDUR) process for State Fiscal Year (SFY) 2012 was made possible by the hard work and commitment of the following members of the New Jersey Drug Utilization Review Board:

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In addition, the following employees assisted the drug utilization review process:

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Robert Kocsardy, R.Ph., Interim Pharmacy Chief, New Jersey Division of Medical Assistance and Health Services, New Jersey Department of Human Services. Special thanks are added to the record in appreciation of continuing education presentations provided by Mr. Kocsardy throughout the State of New Jersey.

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Edward J. Vaccaro, R.Ph., Consultant Pharmacist, Molina Medicaid Solutions.

II. Executive Summary

In accordance with Public Law 1998, chapter 41, the State of New Jersey Department of Human Services and the Department of Health and Senior Services are required by December 1st of each calendar year to provide an annual report, with copies to the United States Department of Health and Human Services, the Governor, the Legislature, the New Jersey Pharmacists Association and the Medical Society of New Jersey. The report includes a description of the highlights and opportunities identified by the New Jersey Drug Utilization Review Board (NJDURB) for the period beginning July 1, 2011 and ending June 30, 2012.

It is important to note that requirements for the Drug Utilization Review (DUR) annual report submitted to the United States Department of Health and Human Services by the New Jersey Division of Medical Assistance and Health Services (DMAHS) differ from those indicated by Public Law 1998, chapter 41 (Appendix A). Information included in this annual report will serve as input to the Federal DUR report.

The NJDURB met quarterly during State Fiscal Year (SFY) 2012. The Board reviewed and discussed drug utilization data for a number of different drug classes as well as individual drugs of interest. Seven prior authorization protocols/initiatives were reviewed and recommended, as well as additional claims processing edits or interventions designed to more effectively monitor and evaluate drug utilization. The NJDURB spent $11,448 in SFY 2012.

As part of the Prospective Drug Utilization Review (PDUR) process, interventions recommended by the NJDURB are designed to prevent adverse drug events and the overutilization/underutilization of medications protecting the patient and preventing fraud, waste and abuse. These interventions offer pharmacists additional information and the opportunity to consult with patients and prescribers. The PDUR program has clearly demonstrated its ability to influence and in some cases, dramatically change prescribing patterns ultimately encouraging appropriate drug utilization, improved health outcomes and the avoidance of unnecessary drug costs.

Appendix B indicates about $20 million in estimated cost savings for SFY 2012 for State pharmacy benefit program through the Medical Exceptions Process (MEP).

It is important to note that the estimated cost savings may be inconsistent with prior reporting. The estimated cost savings for this Report were re-calculated by DMAHS to eliminate duplication errors and to better reflect the added value of the PDUR program. This figure was also impacted by the State's decision to expand enrollment of NJ FamilyCare (NJFC)/Medicaid beneficiaries in Managed Care.

The savings is added value for the PDUR process. The State created PDUR edits such as drug-drug interactions, duplication of drug therapies, and maximum daily doses to identify possible conflicts and ultimately encourage appropriate prescribing and/or drug utilization.

The cost of administering the MEP through Molina Medicaid Solutions for the period of July 1, 2011 through June 30, 2012 was $ $5,282,768.

III. Background

The NJDURB is responsible for reviewing and recommending specific processes for prospective and retrospective components of the DUR process. These processes are intended to improve medication utilization and quality of care.

The Prospective drug utilization review consists of interventions performed by a pharmacist prior to a drug being dispensed to NJFC/Medicaid, Work First New Jersey (WFNJ)/General Assistance (GA), Pharmaceutical Assistance to the Aged and Disabled (PAAD), New Jersey Senior Gold Prescription Discount Program (Senior Gold), Cystic Fibrosis and AIDS Drug Distribution Program (ADDP) beneficiaries who receive drug benefits through the fee-for-service (FFS) program. These interventions may involve consultations with the patient and practitioner regarding drug utilization, including possible severe drug-drug interactions; maximum daily dosage having been exceeded; possible therapeutic duplication (the use of more than one drug in a specific drug class), and situations where the recommended duration for a drug's use may have been exceeded.

Retrospective Drug Utilization Review (RDUR) evaluates these same criteria. However, such reviews are performed on a beneficiary's drug claim history after medications have been dispensed. The process is useful to the State and/or the prescriber in evaluating prescribing patterns. Based on this information, to assure continuous quality assurance, the Board is responsible for performing certain educational outreach activities to bring about changes in these patterns to encourage clinically appropriate drug utilization.

The NJDURB is responsible for recommending PDUR standards to avoid drug-related issues such as duplication of drug therapies, inappropriate dosing, drug-drug interactions, drug-disease contraindications, and inappropriate therapeutic usage. The Commissioners of the Department of Human Services and the Department of Health and Senior Services then consider these standards for approval. These standards are supported by the State's point-of-sale (POS) claims processing system. The POS system provides the opportunity to provide pharmacists with useful drug utilization information prior to a prescription being dispensed.

The official NJDURB website may be found at www.nj.gov/humanservices/dmahs/boards/durb/.

IV. Findings

A. Overview of Activities/Interventions and Impact on Quality of Care

Highlights of Board Activities During SFY 2012 Include:

- **Outcomes Review of DURB-Approved Initiatives**

  Sedative Hypnotics: implemented in July 2009, this protocol encouraged prescribers to evaluate and treat underlying causes of insomnia, instead of relying on the protracted use of sedative hypnotics. Payments and utilization decreased by 66% and 44%, respectively in 2011 compared to 2009 for pharmacy services received by WFNJ/GA beneficiaries.

  Prescription Omega-3 fatty acids*:* implemented in May 2011, this protocol encouraged more efficient use of omega-3 fatty acids. Payments and utilization decreased by 55% and 57%, respectively in 2011 compared to 2010. The State- also experienced a 34 to 40% increase in utilization of alternative medications in the same drug category during this period.

  Selective Non-Steroidal Anti-inflammatory Drugs (NSAIDs): implemented in July 2010, this protocol was intended to ensure appropriate utilization of more cost-effective, non-selective alternatives to the selective class, and in general reduce adverse events associated with NSAID use. Expenditures and utilization (claims quantity) of selective NSAIDs decreased by 65% and 67%, respectively in 2011 compared to 2010. It is noteworthy that even though utilization of non-selective NSAIDs increased slightly by 8%, overall expenditures decreased 18% due to competitive prices among multi-source products found in this category.

  Antipsychotics (atypicals): implemented in April 2011, this protocol was intended to streamline usage due to concerns that these products were being prescribed outside FDA indications, sometimes concomitantly with similar products. Utilization increased by 8% during the remainder of the year compared to the same period in 2010. The vulnerabilities of behavioral health beneficiaries present a dilemma for DMAHS in terms of aggressively enforcing the protocol as has been the practice with other drug categories. Positive clinical communications between the Molina Medicaid Solutions MEP Unit and prescribers are helpful in understanding the prescribing circumstances experienced by prescribers and to the monitoring efforts of the program.

  Diabetes RetroDUR report: The Board evaluated outcomes from a retrospective drug utilization report for diabetic patients. The MEP Unit sent letters to prescribers of diabetes medications. Of the 1082 letters sent between January 1011 and September 2011, 32% or 345 letters were returned. Follow up was performed for 242 of these responses, requesting current A1C levels. Although there was a decrease of 8% (41 patients) in average A1C levels, compared to the baseline, there was also an increase of 17% (36 patients) in average A1C levels compared to the same. The Board members discussed possible contributing factors that could be addressed, such as medication compliance and life-style changes, both improving patient outcomes.

- **Outcomes of Clinical interventions**

***Excessive dose denial outcomes analysis*:** The Board reviewed the outcomes of a report regarding excessive dose for the month of January 2012. The report identified 117 claims. Intervention outcomes are categorized below.

- Dose/strength decreased by prescriber (42%)
- Medication not filled by pharmacy (23%)
- Prescription error (16%)
- Medication changed (12%)
- Cash paid by patient (4%)
- Fraudulent prescription (1%)
- Other (2%)
  The top drugs denied under this category were narcotics – short-acting oxycodone, alprazolam, long-acting oxycodone, hydrocodone-acetaminophen, and tramadol.

Therapeutic duplication denial outcomes analysis: The Board reviewed the outcomes of a report on therapeutic duplication (TD) for the month of April 2012. The report identified 427 TD prior authorization denials. 100 denials were randomly selected for review with the following results:

Two or more prescribers -

- Patient continued previous medication (31)
- Patient paid cash before/after denial [narcotics] (14)
- Pharmacy/patient refilling wrong medication (7)
- Prescriber unaware of duplication medication (15)

One prescriber -

- Continued with previous medication (24)
- Patient paid cash before/after denial [narcotics] (2)
- Pharmacy/patient refilling wrong medication (7)

Top drugs denied under this category were tramadol 50mg, Endocet 10-325mg, oxycodone/apap 5-325, alprazolam 1mg, oxycodone 30mg, alprazolam 2mg, naproxen 500mg, Combivent® inhaler, alprazolam 0.025mg and ibuprofen 600mg.

- **DURB-Recommended Protocols**

  - **Teleprevir (Incivek®):** The Board reviewed and recommended a protocol for the efficient and safe use of telaprevir, a new oral dosage drug form prescribed for the treatment of hepatitis C infected patients.

  - **Fluticasone/salmeterol (Advair®):** The Board reviewed and recommended a protocol for the efficient use of fluticasone/salmeterol, a medication for the treatment of asthma and chronic obstructive pulmonary disease (COPD). The purpose of the protocol was to ensure a trial(s) and a documented insufficient response(s) and/or an adverse response(s) to inhaled corticosteroids. An

addendum was later added to this protocol to incorporate two similar products – mometasone/formoterol (Dulera®) and budesonide/formoterol (Symbicort®).

- **Carisoprodol (Soma®):** The Board reviewed and recommended a protocol for the efficient use of carisoprodol, a central-acting oral muscle relaxant. Reports of abuse and misuse prompted the DEA to classify this product as a controlled substance in December 2011. The Board recommended prior authorization for higher than FDA-recommended doses and durations of drug use exceeding 90 days.

- **Montelukast (Singulair®):** The Board recommended a protocol for montelukast, a medication used for the treatment of asthma, exercise-induced bronchospasm and chronic idiopathic urticaria. Board members recommended that this product also be approved for patients with seasonal/perennial allergic rhinitis who could not tolerate or have failed at least one trial of a non-sedating antihistamine or intranasal corticosteroid.

- **Asthma Medications Management (RetroDur):** The Board recommended a protocol for asthma medication management. This would involve a retrospective review of patient profiles and sending alerts to provide prescribers an opportunity to add a controller medication(s) when needed. Alerts will also be designed to inform practitioners regarding gaps in a patient's refill history. The goal is to reduce morbidity associated with disease exacerbations, ER visits, etc. The Board acknowledged that a short-term increase in cost is possible, but these costs could be offset by long-term reductions in overall healthcare expenditures.

- **Tadalafil (Cialis®):** The Board recommended a protocol for the efficient and safe use of tadalafil (Cialis®) for the treatment of Benign Prostatic Hyperplasia (BPH).

- **Testosterone:** The Board recommended a protocol for the use of testosterone for the treatment of primary and secondary hypogonadism. The protocol would require a baseline testosterone test prior to initiation of therapy.

Mandatory Generic Substitution Drug Program: The Board reviewed and recommended an update to the State's Mandatory Generic Substitution Exempt List for 2003. The changes were as follows:

- The State will continue to exempt behavioral health drugs (antipsychotics and antidepressants).
- Hormone replacement therapy will no longer be exempt.
- Transplant or anti-rejection drugs will be exempt.

The Board discussed the issue of national drug shortages and its impact on the debate regarding generic versus brand-name drug use.

NJ HMO: The State's Acting Chief, Pharmaceutical Services conducted regular meetings with Medicaid HMO Pharmacy Directors and the Board was informed regarding the highlights of these discussions. DMAHS will work closely with the Board to enhance the quality of available information regarding utilization of drugs by NJFC/Medicaid beneficiaries enrolled in managed care. These enhancements will include the development of standardized templates for reports. DMAHS will also work with the HMOs to determine similarities and differences between the DUR standards approved by DURB/DMAHS and those used by HMOs for either clinical reviews or formulary compliance.

Dr. Lichtbroun: One of the Board members, Dr. Alan Lichtbroun, resigned during this reporting period.

All the recommendations made by the Board in SFY 2012 were approved by the Commissioner of the Department of Human Services and the Commissioner of the Department of Health and Senior Services.

Additional information regarding DURB activities may be found at www.nj.gov/humanservices/dmahs/boards/durb/

B. Assessment of Costs

Drug Utilization

The MEP approved 239,662 claims from July 1, 2011 to June 30, 2012. The Top five categories of drugs most often prior authorized include pain medications, anti-anxiety, proton-pump inhibitors, skeletal muscle relaxants and atypical antipsychotics. See Table A below. Top five categories of drugs receiving the most denials included pain medications, proton-pump inhibitors, sedative-hypnotics, non-steroidal anti-inflammatory drugs (NSAIDs) and anti-anxiety drugs. See Table B below. Other reasons for prior authorizations being denied were multiple prescribers; dosage and duration of therapy above established DUR standards; clinical criteria not met; inappropriate diagnosis; and other drug(s) causing a drug-drug interaction.

Table A

Top 5 Authorized Drug Categories:

Therapeutic Category (STC)	Claim Count	Estimated payment amt
Pain meds (H3A)	60,078	$ 7,853,937
Anti-anxiety (H2F)	21,567	$ 623,125
Proton-pump inhibitors (D4J)	18,188	$ 2,126,872
Skeletal Muscle Relaxants (H6H)	16,581	$ 377,574
Atypical Antipsychotics (H7T)	15,211	$ 5,257,886

Table B

Top 5 Denied Drug Categories:

Therapeutic Category (STC)	Claim Count	Estimated Cost-savings
Pain meds (H3A)	9,020	$ 764,383
Proton-pump inhibitors (D4J)	7,214	$ 483,195
Sedative-Hypnotics (H2E)	2,988	$ 146,994
NSAIDs (S2B)	1,791	$ 116,485
Anti-anxiety (H2F)	1,544	$ 21,021

The PDUR program is supported by various edit tables designed to provide maximum flexibility for the State to apply PDUR interventions. These tables include standards for individual Generic Code Numbers or Specific Therapeutic Classes; minimum age; maximum age; standards based on relationships between a claim's reported metric quantity and its days supply; and the ability to immediately deny or override claim denials with prior authorization or allow a 30 day supply of a drug to be dispensed to allow for interventions with the prescriber to take place. PDUR edits prevent adverse reactions and inappropriate drug utilization thereby protecting the patient and preventing fraud, waste and abuse.

C. Recommendations

With 95% of NJFC/Medicaid beneficiaries now enrolled in managed care, the Division will work closely with its managed care partners to develop DUR standards that accommodate the needs of both the remaining fee-for-service (FFS) program and that of managed care. The Division anticipates that existing FFS DUR standards will evolve and more closely resemble those operationalized by managed care. The role of the NJDURB will continue to ensure that medications provided FFS or by HMOs are prescribed to meet the medical necessity needs of our beneficiaries and are utilized appropriately.

Discussions between Division staff and the HMOs are already taking place to standardize the way information is shared and to better understand the informational needs of managed care organizations. The Division has access to encounter claims supplied by HMOs to the State that will be enhanced to evaluate the utilization of medications by HMO members and determine the quality of the prescription services provided. The Division will blend its FFS DUR experiences with those of the HMOs to develop a DUR program that best monitors the quality of drug utilization by the overall NJFC/Medicaid population.

V. Acronyms

ADDP	AIDS Drug Distribution Program
DMAHS	Division of Medical Assistance and Health Services
DUR	Drug Utilization Review
DURB	Drug Utilization Review Board
HIV	Human Immunodeficiency Virus
MEP	Medical Exception Process
NJDURB	New Jersey Drug Utilization Review Board
OTC	Over-the-Counter
PA	Prior Authorization
PAAD	Pharmaceutical Assistance to the Aged and Disabled
PDUR	Prospective Drug Utilization Review
POS	Point-of-Sale
PPI	Proton Pump Inhibitor
RDUR	Retrospective Drug Utilization Review
SFY	State Fiscal Year

VI. Appendices

Appendix A

P.L. 1998, Chapter 41, approved June 30, 1998, as amended and supplemented

§ 30:4D-17.6. Definitions

As used in this act:

"Beneficiary" means a person participating in a State pharmaceutical benefits program.

"Board" means the Drug Utilization Review Board established pursuant to section 2 of P.L.1998, c. 41 (C.30:4D-17.17a) in connection with State pharmaceutical benefits programs.

"Compendia" means those resources widely accepted by the medical professions in the efficacious use of drugs which is based on, but not limited to, these sources: the "American Hospital Formulary Services Drug Information," the "U.S. Pharmacopeia-Drug Information," the "American Medical Association Drug Evaluation," and the peer-reviewed medical literature, and information provided from the manufacturers of drug products.

"Criterion" means those explicit and predetermined elements that are used to assess or measure drug use on an ongoing basis to determine if the use is appropriate, medically necessary, and not likely to result in adverse medical outcomes.

"Department" means the Department of Human Services.

"Drug Interactions" means the occurrence when two or more drugs taken by a recipient lead to clinically significant toxicity that is characteristic of one or any of the drugs present or that leads to the interference with the effectiveness of one or any of the drugs.

"Drug-disease contraindication" means the occurrence when the therapeutic effect of a drug is adversely altered by the presence of another disease or condition.

"Intervention" means a form of educational communication utilized by the Board with a prescriber or pharmacist to inform about or to influence prescribing or dispensing practices.

"Medicaid" means the program established pursuant to P.L.1968, c. 413 (C.30:4D-1 et seq.).

"Over-utilization or under-utilization" means the use or non-use of a drug in quantities such that the desired therapeutic goal is not achieved.

"PAAD" means the program of pharmaceutical assistance to the aged and disabled established pursuant to P.L.1975, c. 194 (C.30:4D-20 et seq.).

"Prescriber" means a person authorized by the appropriate State professional and occupational licensing board to prescribe medications and devices.

"Prospective drug utilization review" means that part of the drug utilization review program that occurs before the drug is dispensed and is designed to screen for potential drug therapy problems based on knowledge of the patient, the patient's continued drug use and the drug use criteria and standards developed by the board.

"Retrospective drug utilization review" means that part of the drug utilization review program that assesses or measures drug use based on an historical review of drug data against criteria and standards developed by the Board on an ongoing basis with professional input.

"Standards" means the acceptable range of deviation from the criteria that reflects local medical practice and that is tested on the beneficiary database.

"State pharmaceutical benefits program" means the following programs: Medicaid, PAAD, Senior Gold, the AIDS drug distribution program, and any other State and Federally funded pharmaceutical benefits program.

"Therapeutic appropriateness" means drug prescribing and dispensing based on rational drug therapy that is consistent with the criteria and standards developed pursuant to P.L.1993, c.16 (C.30:4D-17.16 et seq.) and section 2 of P.L.1998, c. 41 (C.30:4D-17.17a).

"Therapeutic duplication" means the prescribing and dispensing of the same drug or of two or more drugs from the same therapeutic class when overlapping time periods of drug administration are involved and when the prescribing or dispensing is not medically indicated.

HISTORY: L. 1993, c. 16, §1; amended 1998, c. 41, §1.

§ 30:4D-17.17a. Drug Utilization Review Board

a. There is established the Drug Utilization Review Board in the department to advise the department on the implementation of a drug utilization review program pursuant to P.L. 1993, c. 16 (C. 30:4D-17.16 et seq.) and this section. The board shall establish a Senior Drug Utilization Review Committee to address the specific prescribing needs of the elderly and an AIDS/HIV Drug Utilization Review Committee to address the specific prescribing needs of persons with AIDS/HIV, in addition to such other committees as it deems necessary. It shall be the responsibility of each committee to evaluate the specific prescribing needs of its beneficiary population, and to submit recommendation to the board in regard thereto.

The Board shall consist of 17 members, including the Commissioners of Human Services and Health and Senior Services or their designees, who shall serve as nonvoting ex officio members, and 15 public members. The public members shall be appointed by the Governor with the advice and consent of the Senate. The

appointments shall be made as follows: six persons licensed and actively engaged in the practice of medicine in this State, including one who is a psychiatrist and at least two who specialize in geriatric medicine and two who specialize in AIDS/HIV care, one of whom is a pediatric AIDS/HIV specialist, four of whom shall be appointed upon the recommendation of the Medical Society of New Jersey and two upon the recommendation of the New Jersey Association of Osteopathic Physicians and Surgeons; one person licensed as a physician in this State who is actively engaged in academic medicine; four persons licensed in and actively practicing or teaching pharmacy in this State, who shall be appointed from a list of pharmacists recommended by the New Jersey Pharmacists Association, the New Jersey Council of Chain Drug Stores, the Garden State Pharmacy Owners, Inc., the New Jersey Society of Hospital Pharmacists, the Academy of Consultant Pharmacists and the College of Pharmacy of Rutgers, The State University; one additional health care professional; two persons certified as advanced practice nurses in this State, who shall be appointed upon the recommendation of the New Jersey State Nurses Association; and one member to be appointed upon the recommendation of the Pharmaceutical Research and Manufacturers of America.

Each member of the board shall have expertise in the clinically appropriate prescribing and dispensing of outpatient drugs.

b. All appointments to the board shall be made no later than the 60th day after the effective date of this act. The public members shall be appointed for two-year terms and shall serve until a successor is appointed and qualified, and are eligible for reappointment; except that of the public members first appointed, eight shall be appointed for a term of two years and five for a term of one year.

c. Vacancies in the membership of the board shall be filled in the same manner as the original appointments were made but for the unexpired term only. Members of the board shall serve with compensation for the time and expenses incurred in the performance of their duties as board members, as determined by the Commissioners of Human Services and Health and Senior Services, and subject to the approval of the Director of the Division of Budget and Accounting in the Department of the Treasury.

d. The board shall select a chairman from among the public members, who shall serve a one-year term, and a secretary. The chairman may serve consecutive terms. The board shall adopt bylaws. The board shall meet at least quarterly and may meet at other times at the call of the chairman. The board shall in all respects comply with the provisions of the "Open Public Meetings Act," P.L. 1975, c. 231 (C. 10:4-6 et seq.). No motion to take any action by the board shall be valid except upon the affirmative vote of a majority of the authorized membership of the board.

e. The duties of the board shall include the development and application of the criteria and standards to be used in retrospective and prospective drug utilization review. The criteria and standards shall be based on the compendia and developed with professional input in a consensus fashion. There shall be provisions for timely reassessments and revisions as necessary and provisions for input by persons acting as patient advocates. The drug utilization review standards shall reflect the local practices of prescribers, in order to monitor:

(1) therapeutic appropriateness;

(2) over-utilization or under-utilization;

(3) therapeutic duplication;

(4) drug-disease contraindications;

(5) drug-drug interactions;

(6) incorrect drug dosage;

(7) duration of drug treatment; and

(8) clinical drug abuse or misuse.

The board shall recommend to the department criteria for denials of claims and establish standards for a medical exception process. The board shall also consider relevant information provided by interested parties outside of the board and, if appropriate, shall make revisions to the criteria and standards in a timely manner based upon this information.

f. The board, with the approval of the department, shall be responsible for the development, selection, application, and assessment of interventions or remedial strategies for prescribers, pharmacists and beneficiaries that are educational and not punitive in nature to improve the quality of care, including:

(1) Information disseminated to prescribers and pharmacists to ensure that they are aware of the duties and powers of the board;

(2) Written, oral or electronic reminders of patient-specific or drug-specific information that are designed to ensure prescriber, pharmacist, and beneficiary confidentiality, and suggested changes in the prescribing or dispensing practices designed to improve the quality of care;

(3) The development of an educational program, using data provided through drug utilization review as a part of active and ongoing educational outreach activities to improve prescribing and dispensing practices as provided in this section. These educational outreach activities shall include accurate, balanced and timely information about drugs and their effect on a patient. If the board contracts with another entity to provide this program, that entity shall publicly disclose any financial interest or benefit that accrues to it from the products selected or used in this program;

(4) Use of face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been designated by the board for educational intervention;

(5) Intensified reviews or monitoring of selected prescribers or pharmacists;

(6) The timely evaluation of interventions to determine whether the interventions have improved the quality of care; and

(7) The review of case profiles prior to the conducting of an intervention.

HISTORY: L. 1998, c. 41, §2; amended 2003, c. 262.

§ 30:4D-17.18. Responsibilities of department The department shall be responsible for:

a. (Deleted by amendment, P.L.1998, c. 41).

b. The implementation of a drug utilization review program, subject to the approval of the Commissioner of Health and Senior Services, to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes, including the approval of the provisions of any contractual agreement between the State pharmaceutical benefits program and other entities processing and reviewing drug claims and profiles for the drug utilization review program.

The program shall include both retrospective and prospective drug utilization review. Retrospective drug utilization review shall include an analysis of drug claims processing data in order to identify patterns of fraud, abuse or gross overuse, an inappropriate or medically unnecessary care, and to assess data on drug use against standards that are based on the compendia and other sources. Prospective drug utilization review shall include a review conducted by the pharmacist at the point-of-sale.

c. (Deleted by amendment, P.L.1998, c. 41).

d. (Deleted by amendment, P.L.1998, c. 41).

e. The submission of an annual report, which shall be subject to public comment prior to its issuance, to the Federal Department of Health and Human Services by December 1st of each year. The annual report shall also be submitted to the Governor, the Legislature, the New Jersey Pharmaceutical Association and the Medical Society of New Jersey by December 1st of each year. The report shall include the following information:

(1) An overview of the activities of the board and the drug utilization review program;

(2) Interventions used and their ability to improve the quality of care; however, this information shall not disclose the identities of individual prescribers, pharmacists, or beneficiaries, but shall specify whether the intervention was a result of under-utilization or over-utilization of drugs;

(3) The costs of administering the drug utilization review program;

(4) Any cost impact to other areas of the State pharmaceutical benefits program resulting from the drug utilization review program, such as hospitalization rates or changes in long-term care;

(5) A quantitative assessment of how drug utilization review has improved beneficiaries' quality of care;

(6) A review of the total number of prescriptions and medical exception requests reviewed by drug therapeutic class;

(7) An assessment of the impact of the educational program established pursuant to subsection f. of section 2 of P.L.1998, c.41 (C.30;4D-17.17a) and interventions on prescribing or dispensing practices, total program costs, quality of care and other pertinent patient patterns; and

(8) Recommendations for improvement of the drug utilization review program.

f. The development of a working agreement between the board and other boards or agencies, including, but not limited to: the Board of Pharmacy of the State of New Jersey and the State Board of Medical Examiners, in order to clarify any overlapping areas of responsibility.

g. The establishment of an appeal process for prescribers, pharmacists and beneficiaries pursuant to P.L.1993, c.16 (C.30:4D-17.16 et seq) and section 2 of P.L.1998, c.41 (C.30:4D-17.17a).

h. The publication and dissemination of medically correct and balance educational information to prescribers and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among prescribers, pharmacists and beneficiaries, including:
(1) potential or actual reactions to drugs;

(2) therapeutic appropriateness;

(3) over-utilization or under-utilization;

(4) appropriate use of generic drugs;

(5) therapeutic duplication;

(6) drug-disease contraindications;

(7) drug-drug interactions;

(8) incorrect drug dosage or duration of drug treatment;

(9) drug allergy interactions; and

(10) clinical abuse or misuse.

i. the development and publication, with the input of the Board of Pharmacy of the State of New Jersey, of the guidelines to be used by pharmacists, including mail order pharmacies, in their counseling of beneficiaries.

j. The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the drug utilization review program, that identifies individual prescribers, pharmacists, or beneficiaries. The board may have access to identifying information for purposes of carrying out intervention activities, but the identifying information may not be released to anyone other than a member of the board, except that the board may release cumulative non-identifying information for purposes of legitimate research. The improper release of information in violation of this act may subject that person to criminal or civil penalties.

k. The determination of whether nursing or long-term care facilities under 42 CFR 483.60 are exempt from the provisions of this act.

l. The establishment of a medical exception process by regulation.

m. The provision of such staff and other resource as the board requires.

HISTORY: L. 1993, c. 16, § 3; amended 1998, c. 41, § 3.

§ 30:4D-17.18a. Rules, regulations

The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c. 410 (C.52:14B-1 et seq.), and subject to the approval of the Commissioner of Health and Senior Services as appropriate, shall adopt rules and regulation to effectuate the purposes of P.L.1993, c. 16 (C.30:4D-17.16 et seq.) and section 2 of P.L.1998, c. 41 (C.30:4D-17.17a); except that, notwithstanding any provision of P.L.1968, c. 410 (C.52.14B-1 et seq.) to the contrary, the Commissioner of Human Services, subject to the approval of the Commissioner of Health and Senior Services, may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of P.L.1993, c. 16 (C.30.4D-17.16 et seq.) and section 2 of P.L.1998, c. 41 (C.30:4D-17.17a), which shall be effective for a period not to exceed six months and may thereafte4r be amended, adopted, or re-adopted by the Commissioner of Human Services, subject to the approval of the Commissioner of Health and Senior Services, in accordance with the requirements of P.L.1968, c. 410 (C.52:14B-1 et seq.).

HISTORY: L. 1998, c. 41, § 4.

Appendix B

Molina Medicaid Solutions Cost Avoidance Reports

Claims represented in this report did not reappear for future payment and are considered an avoidance of inappropriate expenditures

July 2011 – June 2012

EDIT	ADDP	GA	GOLD	MCAID	PAAD	GRAND_TOTAL
403	$20,741.57	$110,618.90	$14,213.37	$201,642.46	$128,044.07	$475,260.37
404	$23,894.12	$45,695.98	$2,276.35	$171,716.23	$30,368.59	$273,951.27
405	$51,499.20	$396,632.90	$9,909.89	$368,400.35	$95,797.55	$922,239.89
407	$75,485.64	$73,231.24	$118.38	$93,836.25	$12,644.55	$255,316.06
417	$11,200.58	$95,644.65	$8,853.46	$207,345.53	$78,452.80	$401,497.02
447	$412.76	$720.15	$305.16	$7,844.71	$2,000.73	$11,283.51
449	$0.00	$8,833.14	$0.00	$80,767.78	$0.00	$89,600.92
537	$12,739.08	$119,026.41	$7,942.53	$308,576.98	$84,307.02	$532,592.02
577	$0.00	$5,894,079.65	$0.00	$0.00	$0.00	$5,894,079.65
869	$684.78	$4,409.06	$0.00	$17,576.60	$4,627.75	$27,298.19
916	$133,577.37	$107,555.15	$27,581.31	$172,754.15	$295,659.57	$737,127.55
2007	$609,036.34	$3,328,107.75	$14,456.51	$2,921,185.00	$149,756.00	$7,022,541.60
2021	$0.00	$0.00	$0.00	$4,441.16	$0.00	$4,441.16
2038	$15,853.54	$199,907.58	$4,068.21	$712,625.62	$712,625.62	$1,645,080.57
2046	$41,709.15	$324,729.89	$3,625.93	$240,580.12	$43,112.49	$653,757.58
2047	$9,317.33	$1,722.33	$46.06	$7,358.00	$1,140.47	$19,584.19
2085	$1,053.02	$7,226.79	$295.13	$15,441.38	$3,878.80	$27,895.12
2100	$0.00	$420,647.39	$0.00	$479,293.66	$0.00	$899,941.05
2111	$0.00	$8,131.33	$0.00	$3,018.48	$0.00	$11,149.81
GRAND TOTAL	**$1,007,204.48**	**$11,146,920.29**	**$93,692.29**	**$6,014,404.46**	**$1,642,416.01**	**$19,904,637.53**

- Cost savings identified in this report reflect costs for DUR claims denied by a DUR edit for which no future paid claims were identified for the 60 day period following the date of denial.
- This report has been unduplicated by claim and edit.

Description of Edits

403 Duration Exceeded
404 Duration Exceeded
405 Possible Therapeutic Class Duplication
407 Possible duplication of HIV therapy
417 Generic Substitution Required
447 Daily Dose Exceeds Recommended Limits
449 Inappropriate Narcotic Use
537 NJDURB Daily Drug Quantity Exceeded
577 PA Required for WFNJ/GA Drug Coverage
869 Possible Severe Drug-Drug Interaction
916 Severe Drug-Drug Interaction
2007 Prior Authorization Required
2021 Medicare Part D Wraparound Drug Requires PA
2038 First Fill of HIV or High Dose Narcotic
2046 Prescription restricted
2047 PA required: Prescriber/Drug Restricted
2085 Maximum Allowable Cost (MAC) Override
2100 Daily Dose Standard Exceeded
2111 Cough and cold symptoms