Centennial Care Reporting Instructions
Pharmacy – Report #44

Report Objective

To monitor pharmacy utilization and cost, including controlled substances, formulary drugs, non-formulary drugs, over the counter (OTC) drugs, generic drugs, brand drugs, specialty drugs, and drugs billed through the medical benefit. To monitor member lock-in and care coordination, and provider prescribing trends for fraud, waste, and abuse.

General Instructions

The managed care organization (MCO) is required to submit the Pharmacy report on a quarterly basis. This report is due on April 30, July 30, October 30, and January 30 of each year. If a report due date falls on a weekend or a State of New Mexico holiday, receipt of the report the next business day is acceptable. Please adhere to the following reporting periods and due dates.

Quarter	Reporting Period	Report Due Date
1	January 1 – March 31	April 30
2	April 1 – June 30	July 30
3	July 1 – September 30	October 30
4	October 1 – December 31	January 30

An Excel workbook is provided as a separate attachment for submission. Quantitative data and any qualitative data must be entered in the Excel workbook. The MCO must ensure that data is entered in all fields. The report will be considered incomplete if any field is left blank. Use "ND" if there is no data available to report. Use "0" for numerical fields. Use "N/A" if the data field is not applicable. All formulas provided in the workbook shall not be altered by the MCO. An electronic version of the report in Excel must be submitted to the New Mexico Human Services Department (HSD) by the report due date listed above. The report shall be submitted via the State's secure DMZ FTP site. The date of receipt of the electronic version will serve as the date of receipt of the report.

To assist the MCO with the use of the template, all cells within the template are viewable. This allows the user to move the cursor into any cell of the template and enables the user to see the formulas in the cells that calculate automatically. Although certain cells are locked and protected, the user's ability to view the formulas should assist in the MCO's understanding of the template and calculations performed. It is important to note that when populating the templates with data, users are not to use the "cut and paste" function in Excel, as this may cause errors to the cell formulas. Additionally, certain cells have been locked to prevent data entry where data is not required or not applicable to the particular item or category.

Each time the report is submitted, the MCO shall add to and update the same template that was submitted in previous quarters. For example, the report due on July 30 will include data for the first and second quarters. The reporting period of the report will be 1/1/20 through 06/30/20. For sections of this report that capture data for multiple reporting periods, the MCO is required to update previously submitted data based on the most recent information available. Amounts entered into this report are to be based on actual data and exclude any estimates or accruals. **Note that this report captures information based on paid claims with dates of service within the applicable reporting period.** For example, claims

paid in the second quarter with dates of service in the first quarter should be reported in first quarter claims as refreshed data.

The MCO shall submit the electronic version of the report using the following file labeling format: MCO.HSD44.Q#CY##.v#. The "MCO" part of the labeling should be the MCO's acronym for their business name. With each report submission, change the quarter reference (Q# - e.g., Q1), the calendar year (CY## - e.g., CY19), and the version number (v# - e.g., v1), as appropriate. The version number should be "1" unless the MCO is required to resubmit a report for a specified quarter. In those instances, the MCO will use "2" and so on for each resubmission.

The Reporting Period, MCO Name, and Report Run Date must be entered in the fields provided at the very top left corner of the first worksheet in the Report. Using the format illustrated below, enter the start and end dates for the Reporting Period. The MCO Name should be the MCO's full business name. Using the format illustrated below, enter the Report Run Date. The Report Run Date refers to the date that the data was retrieved from the MCO's system. All dates and the MCO name entered on the first worksheet will automatically populate the top of all other worksheets in the report.

Reporting Period	MM/DD/YYYY	through	MM/DD/YYYY
MCO Name	MCO's Full Name		
Report Run Date	MM/DD/YYYY		

Graphs
Certain sections of the report include an accompanying graph tab containing graphs/charts auto-populated with data; data entry is not required within these tabs.

Attestation and Penalties

The MCO shall ensure that all data is accurate and appropriately formatted in the workbook prior to submitting the report. Per Section 7.3 of the Centennial Care contract, failure to submit accurate reports and/or failure to submit properly formatted reports in accordance with the contract may result in monetary penalties of $5,000 per report, per occurrence.

The MCO shall include a signed Centennial Care Report Attestation Form with each Report submitted. Failure to submit a signed attestation form by the Report due date will result in the entire Report being late. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit timely reports may result in monetary penalties of $1,000 per report, per calendar day. The $1,000 per calendar day damage amounts will double every ten calendar days.

Related Contract Requirements

1. Section 4.21 – Reporting Requirements
2. Section 4.10.2.9 – Pharmacy Services
3. Section 7.3 – Failure to Meet Agreement Requirements

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Definitions

Behavioral Health Drugs	For the purposes of this report, all drugs following into the following two digit GPI Drug Groups are considered behavioral health drugs. Medications falling into other GPI-Drug Groups should not be considered behavioral health drugs for the purpose of this report, even if the plan has reason to believe the drugs are being prescribed for behavioral health conditions. **GPI-2 Drug Group** 61 ADHD/Anti-narcolepsy/Anti-obesity/Anorexiants 57 Antianxiety Agents 58 Antidepressants 59 Antipsychotics/Antimanic Agents 60 Hypnotics/Sedatives/Sleep Disorder Agents The same classifications should be used for drugs billed through medical claims as drugs billed through the point of sale pharmacy claims system.
Concurrent Use	Opioids and benzodiazepines: the overlapping use of a benzodiazepine and an opioid for 30 cumulative days or more. Opioids and antipsychotics: the overlapping use of a benzodiazepine and antipsychotics for 30 cumulative days or more. Exclude members who are: • Receiving hospice or palliative care • Receiving treatment for cancer • Residents of an LTC facility, a facility described in section 1905(d) of Section 1927(g) of the Social Security Act, or another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy (applies to opioids and benzodiazepines and opioids and antipsychotics)
Controlled Substances	Controlled substances are those drug products designated as CII-CV by the United States Drug Enforcement Administration.
DAW	Dispense as Written. This field indicates the pharmacy's claim submission indicating any prescriber's instruction regarding substitution of generic equivalents.
DUR	Drug utilization review.
GCN	Generic Code Number. A GCN is a standard number assigned to each strength, formulation, and route of administration of a drug entity. GCN is part of the First Data Bank drug file.
Generic	A drug product that is comparable to a brand/reference drug product in dosage form, strength, route of administration, quality and performance characteristics, and intended use.

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GPI	Generic Product Identifier. A GPI is a standard number assigned to each strength, formulation, and route of administration of a drug entity. GPI is part of the Medi-Span drug file. The two-character GPI-2 Drug Group should be used to identify therapeutic classes. The GPI-8 Drug Name should be used to group individual NDCs into drugs for reporting top drugs. See specific instructions for each section of the report.
Injectable Drugs	Injectable drugs are those products delivered by intramuscular, subcutaneous, intraocular, intravenous or other injection route. Injectable drugs also include drugs delivered by intravenous infusion.
Medical	Clinician-administered drug claims which can include outpatient hospital, clinic, home infusion, and other settings when a drug is paid for outside of a bundled payment rate and billed through the medical benefit. For the purpose of this report, includes only those clinician-administered drugs considered Covered Outpatient Drugs by the Centers for Medicare & Medicaid Services which are eligible for federal drug rebate.
NDC	National Drug Code. The National Drug Code is a unique 10-digit, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Food, Drug, and Cosmetic Act.
Override Request	A one-time request for approval of services rendered due to a specific circumstance and justified by medical necessity. Examples include vacation supply, refill too soon, and lost or destroyed medication.
Physician-administered	A drug administered to the patient by a physician or other clinicians as opposed to a drug that is self-administered by a patient or a family member/caregiver.
Prior Authorization Request	A request for an approval of a number of units of a particular product or service to furnish to a recipient for a specific date or timespan.
Specialty Drug	Specialty drugs are defined as those used by a small number of enrollees or enrollees with complex and chronic diseases that require expensive and challenging drug regimens. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, hemophilia blood factor products, high-cost orphan drug therapies, and therapies that require complex care. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, cancer, enzyme deficiency, hereditary angioedema, pulmonary hypertension, cystic fibrosis, and prevention of RSV.
Traditional Non-Injectable Drugs	Traditional non-injectable drugs are those products not classified as specialty drugs or injectable drugs. Traditional non-injectable drugs include oral dose forms as well as topical, transdermal, rectal, and inhaled dose forms.

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Section I: Analysis

Before entering data in the workbook, ensure that the “Analysis” tab is selected. This section of the report collects qualitative analysis regarding pharmacy claims, utilization management techniques, and plan/PBM operations.

Provide responses to the questions located in the Analysis tab of the report template. For each question, identify any changes compared to previous reporting periods and trends over time and provide an explanation of the identified changes. Additionally, describe any action plans or performance improvement activities addressing any negative changes found during the current reporting period or previous reporting periods.

If the amount of information required to answer any analysis question is expected to significantly exceed the space provided on the “Analysis” tab, the information can be provided on the "Analysis Supplement" tab.

Section II: Summary

The “Summary” tab captures key metrics regarding pharmacy point-of-sale prescription and OTC (over the counter medications, supplements, and supplies) claims for brand and generic prescriptions. The MCO is required to report information based on paid claims with dates of service in the particular month/quarter/CY specified in the template.

Retail claims and mail order claims must be counted as single claims regardless of the days’ supply count.

Medical supplies such as diabetic test strips, insulin syringes, or inhaler spacers paid for through the pharmacy POS benefit should be included in the summary and categorized as brand or generic as appropriate for each product.

Row Header	Row	Description
Claims Paid (Claims)		
Total Pharmacy Claims Paid	1	The total number of Generic and Brand paid claims (Rows 2 thru 4). Amounts in this row are auto calculated; data entry is not required.
Generic	2	The number of paid claims for all generic drugs.
Brand with No Generic Available	3	The number of paid claims for all brand drugs for which a generic was not available.
Brand with Generic Available	4	The number of paid claims for all brand drugs for which a generic was available.
Dispense as Written (DAW)	4a	The number of claims paid for which a prescriber has indicated that a brand is medically necessary for the patient, according to the pharmacy claim submitted.

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Row Header	Row	Description
DAW Denied	4b	The number of claims denied (rejected or not paid) for which a prescriber has indicated that a brand is medically necessary. Report only one denial per patient per medication, even if the same claim was denied multiple times.
Claims Paid (Dollars)		
Total Pharmacy Claims Paid	5	The corresponding dollar amount paid for claims reported in Row 1. Amounts in this row are auto calculated; data entry is not required.
Generic	6	The corresponding dollar amount paid for claims reported in Rows 2 thru 4.
Brand with No Generic Available	7	
Brand with Generic Available	8	
Claims Paid (Avg Paid Amount per Claim)		
Total Pharmacy Claims Paid	9	The corresponding average dollar amount paid per claim for claims and paid amounts reported in Rows 1 thru 8. Amounts in these rows are auto calculated; data entry is not required.
Generic	10	
Brand with No Generic Available	11	
Brand with Generic Available	12	
% of Claims Paid (Claims)		
Generic	13	The percentage of the total pharmacy paid claim count (Row 1) for each category. Amounts in these rows are auto calculated; data entry is not required.
Brand with No Generic Available	14	
Brand with Generic Available	15	
Dispense as Written (DAW)	15a	
% of Claims Paid (Dollars)		
Generic	16	The percentage of the total pharmacy paid claim dollars (Row 5) for each category. Amounts in these rows are auto calculated; data entry is not required.
Brand with No Generic Available	17	
Brand with Generic Available	18	

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Section III: Point of Sale (POS) Utilization Summary

The "POS Utilization" tab captures key metrics regarding claims data for all Pharmacy POS claims. This section also includes a breakout of behavioral health claims.

The MCO is required to report information based on paid claims with dates of service in the particular month/quarter/CY specified in the template.

Row Header	Row	Description
Total Pharmacy Claims Received (Claims)	1	The total number of pharmacy claims (formulary and non-formulary) received with date of service within the month/quarter.
POS CLAIMS - TOTAL (INCLUDING BH)		
Total Claims Processed (Claims)		
Claims Processed	2	Of the pharmacy claims received (Row 1), the number of claims processed (paid or denied). Amounts in this row are auto calculated based on the counts of claims paid or denied (Rows 3 and 4); data entry is not required in this field.
Claims Paid	3	Amounts in this row are auto calculated based on the counts in Rows 3a and 3b; data entry is not required in this field.
Non-Formulary	3a	The total number of non-formulary and formulary claims that were paid. Count a claim as paid only if the claim's final status is paid. If a claim was paid, reversed and paid again, count as only one paid claim.
Formulary	3b	
Claims Denied	4	Amounts in this row are auto calculated based on the counts in Rows 4a and 4b; data entry is not required in this field. Count a claim as denied only if the claim's final status is denied. If a claim was denied, reversed and denied again, count as only one denied claim.
Non-Formulary	4a	The total number of non-formulary and formulary claims that were denied. Report one denial per patient per medication even if the claim was resubmitted and denied multiple times.
Formulary	4b	
Claims Reversed	5	Of the pharmacy claims processed (Row 2), the number of claims that were reversed.
Total Claims Paid (Dollars)		
Claims Paid	6	Amounts in this row are auto calculated based on the amounts in Rows 6a and 6b; data entry is not required in this field.
Non-Formulary	6a	The corresponding dollar amount paid for claims reported in Rows 3a and 3b.
Formulary	6b	

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Row Header	Row	Description
% of Total Claims Received (Claims)		
Claims Processed	7	Of the pharmacy claims received (Row 1), the percentage of claims processed (paid or denied). Amounts in this row are auto calculated; data entry is not required in this field.
% of Claims Processed (Claims)		
Claims Paid	8a	Of the pharmacy claims processed (Row 2), the percentage of claims paid or denied. Amounts in these rows are auto calculated; data entry is not required in this field.
Claims Denied	8b	
% of Claims Paid (Claims)		
Non-Formulary	9a	The percentage of claims paid (Row 3) that were for either non-formulary or formulary claims. Amounts in these rows are auto calculated; data entry is not required in this field.
Formulary	9b	
% of Claims Denied (Claims)		
Non-Formulary	10a	The percentage of claims denied (Row 4) that were for either non-formulary or formulary claims. Amounts in these rows are auto calculated; data entry is not required in this field.
Formulary	10b	
% of Claims Paid (Dollars)		
Non-Formulary	11a	The percentage of dollars for claims paid (Row 6) that were for either non-formulary or formulary claims. Amounts in these rows are auto calculated; data entry is not required in this field.
Formulary	11b	
POS CLAIMS - BEHAVIORAL HEALTH		
The instructions above should be used when completing this section of the table with the following exceptions: • The data in this section is a subset of the POS claims data reported in the table above and should be limited to behavioral health only. • Data reported as behavioral health is based on the type of drug and not the prescriber type. Refer to the definitions section of this report for guidance on classifying behavioral health drugs. • This section includes antipsychotic injectables, which are not included in the table above. Instructions for entering data for this item are provided below.		

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Row Header	Row	Description
Antipsychotic Injectables Claims Paid (Claims)	3c	The total number of claims paid for antipsychotic injectables. Report based on the most current drug listing(s) (e.g., GPI) that most closely identifies the requested drug category, limited to injectables. Include only antipsychotic injectables billed via the pharmacy POS benefit. Antipsychotic injectables include both long acting and short acting products. Examples include haloperidol injection, Risperdal Consta, Zyprexa Relprevv and olanzapine intramuscular injection. Note that this is a subset of the non-formulary and formulary BH claims paid.
Antipsychotic Injectables Claims Paid (Dollars)	6c	The corresponding dollar amount paid for claims reported in Row 3c.

Section IV: Medical Utilization Summary

The “Medical Utilization” tab captures key metrics regarding claims data for medical/clinician-administered drug claims. This section also includes a breakout of behavioral health claims.

Medical utilization includes only those physician or clinician administered drugs billed on professional or institutional claims and paid separately outside of any bundled rate. Do not include any drugs billed through pharmacy POS claims on this tab.

Include only HCPCS claims submitted with an NDC.

If a medical claim contains multiple drugs and any of the listed drugs are non-formulary, this claim should be counted as non-formulary for the purpose of reporting for this section of the report.

The MCO is required to report information based on paid claims with dates of service in the particular month/quarter/CY specified in the template.

Row Header	Row	Description
Total Claims Received (Claims)	1	The total number of claims for physician-administered drugs (formulary and non-formulary) received with date of service within the month/quarter.
MEDICAL CLAIMS FOR PHYSICIAN-ADMINISTERED DRUGS - TOTAL (INCLUDING BH)		
Total Claims Processed (Claims)		
Claims Processed	2	Of the claims received (Row 1), the number of claims processed (paid or denied). Amounts in this row are auto calculated based on the counts of claims paid or denied (Rows 3 and 4); data entry is not required in this field.

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Row Header	Row	Description
Claims Paid	3	Amounts in this row are auto calculated based on the counts in Rows 3a and 3b; data entry is not required in this field.
Non-Formulary	3a	The total number of non-formulary and formulary claims that were paid. Count a claim as paid only if the claim's final status is paid. If a claim was paid, reversed and paid again count as only one paid claim.
Formulary	3b	
Total Claims Paid (Dollars)		
Claims Paid	4	Amounts in this row are auto calculated based on the amounts in Rows 4a and 4b; data entry is not required in this field.
Non-Formulary	4a	The corresponding dollar amount paid for claims reported in Rows 3a and 3b.
Formulary	4b	
% of Total Claims Received (Claims)		
Claims Processed	5	Of the claims received (Row 1), the percentage of claims processed (paid or denied). Amounts in this row are auto calculated; data entry is not required in this field.
% of Claims Processed (Claims)		
Claims Paid	6	Of the claims processed (Row 2), the percentage of claims paid. Amounts in these rows are auto calculated; data entry is not required in this field.
% of Claims Paid (Claims)		
Non-Formulary	7a	The percentage of claims paid (Row 3) that were for either non-formulary or formulary claims. Amounts in these rows are auto calculated; data entry is not required in this field.
Formulary	7b	
% of Claims Paid (Dollars)		
Non-Formulary	8a	The percentage of dollars for claims paid (Row 4) that were for either non-formulary or formulary claims. Amounts in these rows are auto calculated; data entry is not required in this field.
Formulary	8b	

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Row Header	Row	Description
MEDICAL CLAIMS FOR PHYSICIAN-ADMINISTERED DRUGS - BEHAVIORAL HEALTH		
The instructions above should be used when completing this section of the table with the following exceptions: • The data in this section is a subset of the Medical claims data reported in the table above and should be limited to behavioral health only. • Data reported as behavioral health is based on the type of drug and not the prescriber type. Refer to the definitions section of this report for guidance on classifying behavioral health drugs. • This section includes items not included in the table above. Instructions for entering data for these items are provided below.		
Antipsychotic Injectables Claims Paid (Claims)	3c	The total number of medical claims paid for antipsychotic injectables. Antipsychotic injectables include both long acting and short acting products. Examples include haloperidol injection, Risperdal Consta, Zyprexa Relprevv and olanzapine intramuscular injection. Note that this is a subset of the non-formulary and formulary BH claims paid.
Antipsychotic Injectables Claims Paid (Dollars)	4c	The corresponding dollar amount paid for claims reported in Row 3c.
Unduplicated Count of Members Receiving Methadone at Methadone Clinics for Opioid Dependence	9	The unduplicated count of members who received methadone at a clinic for treatment of opioid dependence for at least one day of service during the particular month/quarter.

Section V: Ranking of Top 5 Drugs

Before entering data in the workbook, ensure that the "Ranking of Top 5 Drugs" tab is selected. This section of the report requires that the MCO rank the top 5 drugs by paid amount and by claim count for each of the following categories: all drugs, brand drugs, generic drugs, traditional non-injectables, injectables (brand and generic), controlled substances, and specialty drugs.

Each quarter, the MCO must rank the top 5 drugs for each category in descending order according to dollar amount paid (upper table) and claim count (lower table). The MCO must update previously reported data each time the report is submitted.

When ranking the top 5 drugs in the "All Drugs" category, use the drug base name as identified by the GPI 8 description.

When ranking top brand and specialty drugs, group all of the strengths, dose forms, and package sizes together. For example, all Abilify products, including Abilify tablets, Abilify Discmelt and Abilify Maintena should be grouped together. When reporting the drug name, use the brand name, for example "Abilify."

When ranking top generics, traditional non-injectables, injectables, and controlled substances, use the GPI-8 Drug Name) classification to group drugs so that multiple strengths, dosage forms, and salts of the

same drug are grouped together. When reporting the drug name, use the drug moiety name consistent with the GPI-8 classification. For example, report "dexamethasone" for products that fall into the 22-10-00-20-XX classification, including dexamethasone acetate, dexamethasone sodium phosphate, Decadron, DexPak and other dexamethasone products.

Data entered on this tab should be limited to pharmacy POS claims. Do not include drugs paid through medical claims.

Column Header	Description
Drug Name	The name of the prescribed drug. For brand and specialty, use the brand name. For generic, traditional non-injectables, injectables, and controlled substances, use the generic drug moiety name consistent with the GPI-8 Drug Name classification.
Therapeutic Class Code	The therapeutic class code of the prescribed drug. Use the GPI-2 Drug Group in the XX-00-00-00-00 format. For example, report all Beta Blockers as 33-00-00-00-00.
Therapeutic Class Code Description	The description associated with the two-digit GPI Drug Group. For example, "Beta Blockers"
Patient Count	The unique count of patients for the prescribed drug with dates of service within the reporting period.
Paid Claim Count	The number of claims paid for the prescribed drug with dates of service within the reporting period.
Total Amount Paid	The corresponding paid amount for the paid claim counts.

Section VI: Ranking of Physician-Administered Drugs

Before entering data in the workbook, ensure that the "Ranking Physician-Administered" tab is selected. This section of the report is limited to drugs billed through medical benefit using HCPCS codes and requires that the MCO rank the top 10 physician-administered drugs and top 10 physician-administered injectable drugs in descending order by total amount paid.

Each quarter, the MCO must rank the top 10 drugs in descending order according to dollar amount paid. The MCO must update previously reported data each time the report is submitted.

When ranking the top 10 physician-administered drugs, use the GPI-8 Drug Name classification to group drugs so that multiple strengths, dosage forms, and salts of the same drug are grouped together. When reporting the drug name, use the drug moiety name consistent with the GPI-8 Drug Name classification. For example, you should report "dexamethasone" for products that fall into the 22-10-00-20-XX classification, including dexamethasone acetate, dexamethasone sodium phosphate, Decadron, DexPak and other dexamethasone products.

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Data entered on this tab should be limited to drugs billed using HCPCS or CPT codes on professional or institutional claims.

All products considered Covered Outpatient Drugs by CMS should be included in this report, including products billed using J-Codes, C-Codes, and CPT codes. Include only HCPCS claims submitted with an NDC. Include only drugs that are reimbursed separately from other services. Do not include the utilization of products which are reimbursed as part of a bundled rate.

Do not include drugs paid for through the pharmacy POS system. Prescriptions processed through point of sale (POS) pharmacy claims should not be included, even if the drugs were ultimately administered by a physician or other clinician.

Column Header	Description
Drug Name	The drug moiety name consistent with the GPI-4 classification.
Therapeutic Class Code	The therapeutic class code of the prescribed drug. Use the GPI-2 drug group code in the XX-00-00-00-00 format. For example, report all Beta Blockers as 33-00-00-00-00.
Therapeutic Class Code Description	The description associated with the GPI-2 drug group code. For example, “Beta Blockers”
Paid Claim Count	The number of claims paid for the prescribed drug with dates of service within the reporting period. Count as “1” each paid claim that includes at least one claim line for the drug that was reimbursed an amount greater than zero. A claim that includes multiple lines of different drugs can be counted on multiple drug lines in this report. A claim that includes multiple lines of the same drug should only be counted once for that drug. Do not count claims if the claim line associated with the drug is paid at zero or denied.
Total Units	The total number of units paid. Number of units should be determined by the number of HCPCS or CPT units for which the plan paid an amount greater than zero. Do not include the units associated with claims paid at zero dollars.
Total Amount Paid	The corresponding total dollar amount paid for the prescribed drug. Include only the amount paid for the drug line. Do not include the amount paid for any other claim lines such as an administration fee, medical supplies, or a facility fee.

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Section VII: Top Prescribers

Before entering data in the workbook, ensure that the "Top Prescribers" tab is selected. This section of the report requires that the MCO rank and identify the top 5 prescribers who had the highest script count for each drug category and member age group. Data by total prescriber and prescribers writing multiple prescriptions for a single member is also captured by each drug category and member age group.

Top prescribers should be defined based only on pharmacy point of sale utilization. Do not include physician administered drugs billed through medical claims.

Report based on the most current drug listing(s) (e.g., GPI) that most closely identifies the requested drug category.

Prescribers must be ranked by total number of prescriptions for the drug category/age group.

Age group shall be determined based on the member's age on the date of service.

Count each paid claim as one prescription.

Count only paid claims with dates of service in the current reporting period.

Prescriber Ranking Section

Column Header	Column	Description
Drug Category / Member Age Group	A	Drug categories: Antipsychotics Opioids CNS Stimulants Benzodiazepines Member age groups are listed in the template and vary by drug category.
Ranking	B	The rank (1 through 5) assigned to the prescriber based on the count of dispensed scripts. The prescriber with the highest prescription count for the category should be ranked #1, the prescriber with the second highest prescription count ranked #2, and so forth.
Prescriber Name (Last, First, Designation)	C	The last name, first name and designation (MD, DO, PA, NP, etc.) of the prescriber.
Rank Previous Reporting Period	D	The prescriber's rank the previous reporting period for the same category, if applicable. Enter N/A if the prescriber was not ranked in the previous period. When the current reporting period is the first quarter of a calendar year, rankings reported in this column should reflect rankings from the fourth quarter of the previous calendar year.
Provider Specialty	E	Use the dropdown to select the prescriber's provider specialty.

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Column Header	Column	Description
Prescriptions (Count)	F	The count of prescriptions for the given category and age group written by the prescriber and paid for by the MCO. Count each paid claim as one prescription. Include only paid claims with dates of service in the current reporting period.
Prescriptions (Dollars)	G	The corresponding dollar amount paid for prescriptions reported in Column F. Include any dispensing fee(s) paid to the pharmacy.
Members Receiving Prescription (Unduplicated Count)	H	The count of members in the age group receiving at least one prescription for the drug category (e.g., antipsychotics) written by the ranked prescriber with dates of service during the reporting period.
% of Members Receiving Prescription	I	Column H/ J. Amounts in this column are auto calculated; data entry is not required.
Members Receiving ANY Prescription from Prescriber (Unduplicated Count)	J	The unduplicated count of members in the age group for which the prescribing provider wrote any prescription for any drug that was paid for by the MCO. Include only paid claims with dates of service in the current reporting period.

Total Prescriber Summary Section

Data applicable to Rows 1 and 2 is required for each drug category/age group.

Row Header	Row	Description
Total All Prescribers	1	Total number of unique prescribers who wrote one or more prescriptions for any drug in the given drug category/age group. Enter the unduplicated count of prescribers in Column E1. Enter applicable data for Columns F, G, H & J, as directed above.
Prescribers Writing Multiple Prescriptions for Single Member	2	Of the total number of unique prescribers (Row 1), the number of prescribers that wrote multiple prescriptions for drugs in the given drug category/age group for a single member. Enter the unduplicated count of prescribers in Column E1. Enter applicable data for Columns F, G, H & J, as directed above.

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Section VIII: Member Lock-in

Before entering data in the workbook, ensure that the "Member Lock-in" tab is selected. This section of the report captures information regarding members who over-utilize drugs and are locked-in to a prescribing provider, pharmacy, or both.

There are two parts to this section of the report: Summary Tables (upper portion) and Member Lock-In Details (lower portion).

The MCO must update previously reported data each time the report is submitted.

Summary Tables

This section if the report captures summary data in five different tables: (1) Member Lock-In by Quarter, (2) Enrollment, (3) Pharmacy Only Lock-In, (4) Prescribing Provider Only Lock-In, and (5) Prescribing Provider and Pharmacy Lock-In.

Row Header	Row	Description
Member Lock-In by Quarter		
Beginning Number of Members in Lock-In	1	Number of members enrolled in lock-in at the beginning of the reporting period.
Number of Members Added to Lock-In During Reporting Period	2	Number of members added to lock-in during the reporting period.
Number of Members Removed from Lock-In During Reporting Period	3	Number of members removed from lock-in during the reporting period.
Ending Number of Members In Lock-In	4	Number of members enrolled in lock-in on the last day of the reporting period. Amounts in this row are auto calculated; data entry is not required in this field.
Enrollment		
Number of Members Actively Enrolled in Lock-In During Reporting Period	5	Number of members actively enrolled in lock-in at some point during the reporting period. Include individuals even if they were not actively enrolled at the end of the quarter.
Number of Members Unable to Reach for Initial Contact Letter/Call	6	Number of members not reached when attempting to notify about lock-in.
Number of Lock-Ins in Process (Pending)	7	Number of members in the process of being locked-in.
Pharmacy Only Lock-In		
Beginning Number of Members in Pharmacy Only Lock-In	8	Number of members enrolled in pharmacy only lock-in at the beginning of the reporting period.
Number of Members Added to Pharmacy Only Lock-In in Reporting Period	9	Number of members added to pharmacy only lock-in during the reporting period.
Number of Members Removed from Pharmacy Only Lock-In in Reporting Period	10	Number of members removed from pharmacy only lock-in during the reporting period.

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Row Header	Row	Description
Ending Number of Members In Pharmacy Only Lock-In	11	Number of members enrolled in pharmacy only lock-in on the last day of the reporting period. Amounts in this row are auto calculated; data entry is not required in this field.
Prescribing Provider Only Lock-In		
Beginning Number of Members in Prescribing Provider Only Lock-In	12	Number of members enrolled in prescribing provider only lock-in at the beginning of the reporting period.
Number of Members Added to Prescribing Provider Only Lock-In in Reporting Period	13	Number of members added to prescribing provider only lock-in during the reporting period.
Number of Members Removed from Prescribing Provider Only Lock-In in Reporting Period	14	Number of members removed from prescribing provider only lock-in during the reporting period.
Ending Number of Members In Prescribing Provider Only Lock-In	15	Number of members enrolled in prescribing provider only lock-in on the last day of the reporting period. Amounts in this row are auto calculated; data entry is not required in this field.
Prescribing Provider AND Pharmacy Lock-In		
Beginning Number of Members in Prescribing Provider AND Pharmacy Lock-In	16	Number of members enrolled in prescribing provider and pharmacy lock-in at the beginning of the reporting period.
Number of Members Added to Prescribing Provider AND Pharmacy Lock-In in Reporting Period	17	Number of members added to prescribing provider and pharmacy lock-in during the reporting period.
Number of Members Removed from Prescribing Provider AND Pharmacy Lock-In in Reporting Period	18	Number of members removed from prescribing provider and pharmacy lock-in during the reporting period.
Ending Number Of Members in Prescriber AND Pharmacy Lock-In	19	Number of members enrolled in prescriber and pharmacy lock-in on the last day of the reporting period. Amounts in this row are auto calculated; data entry is not required in this field.

Member Lock-In Details

The member must remain on the report until a "lock-in end date" is provided. If additional rows are needed, insert rows above the final row (Row 50) in the table as this will ensure the functionality of the dropdown selection boxes are included in the added rows.

Column Header	Column	Description
Member Name	A	The member's first and last name. Enter as Last Name, First Name.
Member Medicaid ID Number	B	The member's Medicaid ID number.
Care Coordination Provided (Yes/No)	C	Use the dropdown to select yes/no to indicate whether or not care coordination was provided to the member.
Date Member Notified of Intent to Lock-in	D	The date the member was notified of the intended lock-in.

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Column Header	Column	Description
Actual Lock-in Date	E	The date that the member was locked-in to the pharmacy or provider.
Lock-in End Date	F	The date the member's lock-in ended.
Re-Review Date of Lock-in	G	The date the member's lock-in was reviewed.
Prescribing Provider Only Lock-In Only (Yes/No)	H	Use the dropdown to select yes/no to indicate whether or not the member is enrolled in prescribing provider only lock-in.
Pharmacy Lock-In Only (Yes/No)	I	Use the dropdown to select yes/no to indicate whether or not the member is enrolled in pharmacy only lock-in.
Prescribing Provider AND Pharmacy Lock-In (Yes/No)	J	Use the dropdown to select yes/no to indicate whether or not the member is enrolled in prescribing provider AND pharmacy lock-in.
Criteria for Member Lock-In or Removal From Lock-In Status	K	Use the dropdown to select the applicable description of the criteria used to determine the member was eligible for lock-in or to determine the member no longer required lock-in.
Description of "Other" Criteria	L	Required when "Other" selected in Column K. Enter a brief description of the criteria used to determine the member was eligible for lock-in or to determine the member no longer required lock-in.

Section IX: Therapeutic Class for Calendar Year

Before entering data in the workbook, ensure that the "Therapeutic Class – CY" tab is selected. This section of the report captures information regarding pharmacy utilization for the calendar year.

There are three parts to this section of the report: Summary (leftmost table), Detail – POS (middle table), and Detail – Medical (rightmost table).

For the purpose of this report, use the GPI-2 drug group classification to group drugs into therapeutic classes. Use the description associated with the GPI-2 to name the therapeutic classes. For example, GPI 25 represents all contraceptives. MCOs should report multi-ingredient (claims with more than one ingredient line) compounded prescriptions as a separate GPI grouping such as "00" which is listed as Compound/Special. Single ingredient compounded prescriptions should be reported to the relevant GPI bucket that matches the single ingredient.

Use the GPI-4 drug class to separate out diabetic supplies from other medical supplies and devices. Group all diabetic supplies (test strips, lancets, meters, syringes) into one therapeutic class using GPI-497-20 and group all other medical supplies/DME falling into GPI-2 97 into another therapeutic class.

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Summary

Reported amounts are to be based on paid claims with dates of service in the quarter/YTD time periods.

Column Header	Row	Description
Therapeutic Class Codes (Counts)		
Total POS & Medical	1	Amounts in this row are auto calculated; data entry is not required in this field.
POS	1a	The number of unique therapeutic classes associated with the claims paid in Rows 3a and 3b. Count therapeutic classes at the GPI-2 drug group level. For non-drug supplies, count diabetic supplies as one therapeutic class using the GPI-4 97-20 and all other DME/supplies falling into GPI-2 97 as another therapeutic class. Counts of unique therapeutic classes must be entered for each completed quarter AND YTD.
Medical	1b	
Total Paid Amount (Dollars)		
Total POS & Medical	2	Amounts in this row are auto calculated; data entry is not required in this field.
POS	2a	The corresponding amount paid for paid claims in Rows 3a and 3b.
Medical	2b	
Claims Paid (Claims)		
Total POS & Medical	3	Amounts in this row are auto calculated; data entry is not required in this field.
POS	3a	The number of claims paid for prescribed drugs in all therapeutic classes. For Medical claims, count each medical claim only once even if it contains multiple drug lines. Do not count medical claims for which all drug lines were paid at zero or included in a bundled rate per procedure or per encounter.
Medical	3b	
Average Amount Paid Per Claim		
Total POS & Medical	4	The average dollar amount paid for each claim across all therapeutic classes. Amounts in these rows are auto calculated; data entry is not required in this field.
POS	4a	
Medical	4b	

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Detail – POS / Detail – Medical

These two tables provide details of all prescribed therapeutic classes dispensed in the current quarter and previous quarter. Reported amounts are to be based on paid claims with dates of service in the current quarter and previous quarter time periods.

Column Header	Column	Description
Therapeutic Class Code	A	The therapeutic class code. Use the two-digit GPI-2 drug class code. For example, 33 represents Beta Blockers.
Therapeutic Class Code Description	B	The therapeutic class code description associated with the GPI-2 in Column A. For example, "Beta Blockers."
Current Quarter Number of Claims Paid	C	The total number of claims paid for the prescribed drugs in the therapeutic class. For Medical claims, count each medical claim only once even if it contains multiple drug lines. Do not count medical claims for which all drug lines were paid at zero or included in a bundled rate per procedure or per encounter.
Current Quarter Total Amount Paid	D	The corresponding amount paid for paid claims in Column C. **Sort each table from highest to lowest (descending) based on the dollar amounts reported in this column.**
Current Quarter Average Amount Paid per Claim	E	The average dollar amount paid per claim in the current quarter, calculated by dividing the total amount paid for the therapeutic class (Column D) by the number of claims paid in the therapeutic class (Column C). For Medical claims, include only the amount paid for the drugs in the therapeutic class displayed. Do not include any payment amount for other drugs on the claim or other non-drug services such as administration fees, supplies, or facility fees.
Previous Quarter Number of Claims Paid	F	The total number of claims paid for the prescribed drugs in the therapeutic class. For Medical claims, count each medical claim only once even if it contains multiple drug lines. Do not count medical claims for which all drug lines were paid at zero or included in a bundled rate per procedure or per encounter. When the current quarter is the first quarter of a calendar year, data reported in this column should reflect data from the fourth quarter of the previous calendar year.
Previous Quarter Total Amount Paid	G	The corresponding amount paid for paid claims in Column F.
Previous Quarter Average Amount Paid per Claim	H	The average dollar amount paid per claim in the previous quarter, calculated by dividing the total amount paid for the therapeutic class (Column G) by the number of claims paid in the therapeutic class (Column F).

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Section X: Drug Utilization Review (DUR)

Before entering data in the workbook, ensure that the "DUR" tab is selected. This section of the report captures information regarding the MCO's prospective and retrospective drug utilization review program.

This section contains four parts: 1) Prospective DUR – Percentage of Claims Denied at POS, 2) Atypical Antipsychotics, Stimulants, And Opioids, 3) Top 10 Prior Authorization Requests, and 4) Retrospective DUR

Prospective DUR – Percentage of Claims Denied at POS

This table captures information about the prospective DUR edits applied by the MCO and the percent of claims denied at POS for each denial reason listed in the table. Reported amounts are to be based on claims with dates of service in the particular quarter. Data for all completed quarters should be updated each quarter as new claims are submitted.

For each completed quarter and denial reason, report the percent of claims denied due to DUR edits that were attributed to the particular DUR denial reason. If a claim is denied for more than one DUR edit, it should be counted in the percentage for each edit posting a denial. For example, if a claim is denied for both early refill and quantity limit, the claim should be included in the numerator for both the early refill and the quantity limit lines. Note that because a claim can be counted in more than one DUR denial category, the sum of the percentages is likely to exceed 100%.

Reported percentages are to be calculated by dividing the number of claims that posted the listed DUR edit by the total number of claims denied at POS due to DUR edits.

For both the numerator and the denominator, one denial should be counted per patient per prescription, even if the prescription was submitted and denied multiple times.

Atypical Antipsychotics, Stimulants, And Opioids

Reported amounts are to be based on paid claims with dates of service in the particular quarter. Data for all completed quarters should be updated each quarter as new claims are submitted.

Age group shall be determined based on the member's age on the date of service.

Report based on the most current drug listing(s) (e.g., GPI) that most closely identifies the requested drug category.

Atypical Antipsychotics

Row Header	Row(s)	Description
Ages 5 And Under / Ages 6 Through 18		
Rows 1 through 6: report data for all children, including Foster Children. Rows 1a through 6a: limit data to Foster Children only (COE 017, 037, 046, 047, 066, 086)		
Distinct Number of Children Receiving at Least One Atypical Antipsychotic Prescription	1/4 1a/4a	The number of distinct members within the age group with at least one paid claim for an atypical antipsychotic.

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Row Header	Row(s)	Description
Distinct Number of Children Receiving Two or More Different Antipsychotic Prescriptions	2/5 2a/5a	The number of distinct members within the age group with at least one paid claim for two different atypical antipsychotics with dates of service within the reporting period. A different atypical antipsychotic means a different drug, not just a refill or a different strength or dosage form of the same drug. For example, Seroquel and Seroquel XR would not be considered different drugs, but Abilify and Seroquel would be.
Percent of the Children Receiving Antipsychotics Who Have Received Metabolic Monitoring Lab Tests in the Last 12 Months	3/6 3a/6a	Percent of children who have received at least one antipsychotic who have a claim for metabolic monitoring labs within 12 months of the date of service of the pharmacy claim. Metabolic monitoring labs include fasting glucose, hemoglobin A1c, and fasting lipids.

Stimulants

Row Header	Row	Description
Children Ages 17 And Under		
Distinct Number of Children Receiving at Least One Stimulant Prescription	7	The number of distinct members ages 17 and under with at least one paid claim for a stimulant.
Distinct Number of Children Receiving Two or More Different Stimulant Prescriptions	8	The number of distinct members ages 17 and under with at least one paid claim for two different stimulants with dates of service within the reporting period. A different stimulant means a different drug, not just a refill or a different strength or dosage form of the same drug. For example, Adderall and Adderall XR would not be considered different drugs, but Adderall XR and Vyvanse would be.
Adults Ages 18 And Older		
Distinct Number of Adults Receiving at Least One Stimulant Prescription	9	The number of distinct members ages 18 and older with at least one paid claim for a stimulant.
Distinct Number of Adults Receiving Two or More Different Stimulant Prescriptions	10	The number of distinct members ages 18 and older with at least one paid claim for two different stimulants with dates of service within the reporting period. A different stimulant means a different drug, not just a refill or a different strength or dosage form of the same drug. For example, Adderall and Adderall XR would not be considered different drugs, but Adderall XR and Vyvanse would be.

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Row Header	Row	Description
Number of Prior Authorizations for Stimulants Requested for Adult Members	11	The number of stimulant prior authorization requests for adult members received during the reporting period. Count each request per patient per medication only once even if the same request is submitted multiple times.
Percentage of Prior Authorizations Approved	12	The percentage of stimulant prior authorization requests for adult members (Row 11) that were approved.
Percentage of Prior Authorizations Denied	13	The percentage of stimulant prior authorization requests for adult members (Row 11) that were denied.

Opioids

Row Header	Row	Description
Distinct Number of Members Receiving at Least One Prescription for Opioids Over 90MME	14	The number of distinct members with at least one paid claim for an Opioid over 90MME.
Distinct Number of Members Receiving Concurrent Prescriptions for Opioids and Benzodiazepines	15	The number of distinct members with concurrent use of Opioids and Benzodiazepines.
Distinct Number of Members Receiving Concurrent Prescriptions for Opioids and Antipsychotics	16	The number of distinct members with concurrent use of Opioids and antipsychotics.
Distinct Number of Members Assigned to Care Coordination	17	The number of distinct members reported in Rows 14 through 16 who were assigned to Care Coordination, regardless of Care Coordination level.

Top 10 Prior Authorization Requests

Top 10 PA Requests by Drug Name (Non-Formulary)

List the 10 top prior authorization requests by drug name, with 1 representing the drug with the most prior authorization requests during the reporting period. **For the purpose of reporting data in this table, report the prior authorizations based on the date of determination, not the submitted date.**

Include both approved and denied prior authorizations. Count each request per patient per medication only once even if the same request is submitted multiple times. Include only requests for non-formulary prescription drugs. Do not include override requests for formulary drugs.

To create the ranking, group all of the strengths, dose forms and package sizes together. For example, all Abilify products, including Abilify tablets, Abilify Discmelt and Abilify Maintena should be grouped together. When reporting the drug name, use the brand name, for example “Abilify.” When reporting the drug name, report the brand name if no generic is available or if only the branded product requires prior authorization. Report the generic name if both brand and generic products are available and both require prior authorization.

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Report the percentage approvals and percentage denials for each of the top 10 drugs. Percent approvals is defined as the number of PA approvals divided by the number of PA requests. Percent denials is defined as the number of PA denials divided by the number of PA requests.

Top 10 PA Requests by Drug Class (Formulary)

List the top 10 prior authorization requests by formulary drug class, with 1 representing the drug class with the most prior authorization requests during the reporting period. **For the purpose of reporting data in this table, report the prior authorizations based on the date of determination, not the submitted date.**

Count each request per patient per medication only once even if the same request is submitted multiple times.

To create the ranking, use the GPI-4 drug class grouping. For example, SSRIs would all be grouped together under the 58-16-XX-XX-XX grouping. When reporting the drug class, report the drug class description consistent with the GPI-4 f grouping.

Report the percentage approvals and percentage denials for each of the top 10 drug classes. Percent approvals is defined as the number of PA approvals divided by the number of PA requests. Percent denials is defined as the number of PA denials divided by the number of PA requests.

Retrospective DUR

All plans are expected to operate a retrospective Drug Utilization Review program consistent with the requirements of section 1927 of the Social Security Act including periodic examination of claims data and other records, assessment of drug use against explicit predetermined standards and educational outreach to providers. Standards for assessment may include but are not limited to monitoring over and underutilization, therapeutic duplication, drug-drug and drug-disease interactions and clinical abuse/misuse. Drug utilization review is required to include both prescriptions paid for through the pharmacy POS claims system as well as clinician-administered drugs paid for through the medical benefit.

The retrospective DUR section of the report should be updated each quarter to include all initiatives which have taken place in the last year.

Column Header	Column(s)	Description
Retrospective DUR Review Number	A	Add rows as needed to list all DUR activities during the reporting period. Provide a brief title of the DUR activity. For example, “stimulant use in adults.”
Describe (Name/Subject) Retrospective Reviews Implemented During Reporting Period	B	Provide a description of the DUR activity including the focus of the study and parameters reviewed. For example, “Reviewed prescribing of stimulants for adult members. Identified outliers with high dose, polypharmacy, or drug-disease contraindications. Used FDA approved dose as high dose threshold for identifying outliers.”

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Column Header	Column(s)	Description
Number of Members Targeted	C	Number of members identified as targets for the DUR educational initiative.
Type of Contact	D	Provide a description of the delivery mechanism used for the DUR educational initiative. Response can be mail, telephone, electronic, fax, etc.
Number of Contacts	E	Number of providers contacted as a result of the DUR initiative via the type(s) of contact identified in Column D.
Number of Responses	F	Number of contacted providers (Column E) who responded.
Response Rate	G	The number of responses (Column F) divided by the number of contacts (Column E) expressed as a percentage. Amounts in this column are auto calculated; data entry is not required.
Type of Provider Targeted	H	The type of provider targeted. Examples: physicians, specialties, pharmacies, etc.
Timeframe of Retrospective DUR Initiative	I	The time period of the retrospective DUR initiative, reported in months and years. For example, 1-2018 through 3-2018

Section XI: Controlled Substances

Before entering data in the workbook, ensure that the "Controlled Substances" tab is selected. This section of the report captures information regarding the MCO's oversight of controlled substance drugs.

"Controlled Substances" refers to drugs classified under the Controlled Substances Act (CSA), which are divided into five schedules and includes both opioid and non-opioid drugs. An updated list of the controlled schedules is published annually in Title 21 Code of Federal Regulations (C.F.R.) §§ 1308.11 through 1308.15. The most current list applicable to each quarter/YTD time period should be used when completing this section of the report.

This section contains 2 parts: 1) measures with corresponding counts/averages (upper tables), and 2) list of drug names (lower tables). Each part includes tables specific to opioids and non-opioids.
For purposes of the Controlled Substances section of this report, "opioids" should be reported separately from "non-opioid" Controlled Substances as outlined below:

Opioids

Opioids include the commonly prescribed painkillers such as oxycodone (OxyContin®) and hydrocodone (Vicodin®), as well as some cough and cold products that contain codeine. All opioids, regardless of use, are to be included in the report.

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Non-Opioids

Non-opioid controlled substances include drugs used for a wide range of indications such as carisoprodol (Soma) and tramadol (Ultram), as well as amphetamines, benzodiazepines, anticonvulsants. All non-opioid controlled substance drugs, regardless of therapeutic class or indication, should be included in the report.

Reported amounts are to be based on paid claims with dates of service in the current quarter and previous quarter time periods.

Controlled Substances: Opioids and Non-Opioids

Column Header	Row #	Description
Number of Paid Claims for Class II Controlled Substances	1	The total number of paid claims for Class II controlled substances. YTD amounts in this row are auto calculated.
Number of Paid Claims for Class III-V Controlled Substances	2	The total number of paid claims for Class III, IV, and V controlled substances with a date of service occurring in the requested quarter. YTD amounts in this row are auto calculated.
Number of Prescribers Writing for Controlled Substances	3	The total number of unique prescribers identified on paid claims with dates of service in the quarter/YTD period for all forms of controlled substances (including cough and cold products).
Average Number of Tablets (units) per Prescription	4	Enter the average number of tablets (units) per prescription where average is the total number of units dispensed divided by the total number of prescriptions dispensed. Averages are to be calculated using paid claims with dates of service in the quarter/YTD period.
Average Day Supply per Prescription	5	Enter the average day supply per prescription where average is the total day supply divided by the total number of prescriptions dispensed. Averages are to be calculated using paid claims with dates of service in the quarter/YTD period.
Number of Unique Members Having Filled 3 or More Controlled Substance Prescriptions	6	The total number of unique members with three or more controlled substance prescription fills with a date of service in the quarter. For YTD amounts, enter the unduplicated count of unique members included in counts across all completed quarters.
Number of Unique Members Filling Controlled Substances at 2 or More Unique Pharmacies	7	The total number of unique members with controlled substance prescription fills with a date of service occurring in the quarter, where the prescriptions are picked up at two or more unique pharmacies. A unique pharmacy is defined by a unique pharmacy ID number. For YTD amounts, enter the unduplicated count of unique members included in counts across all completed quarters.

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Column Header	Row #	Description
Number of Members Receiving Controlled Substance Prescriptions from 2 or More Prescribers	8	The total number of members receiving controlled substance prescriptions in the quarter written by two or more different providers. For YTD amounts, enter the unduplicated count of unique members included in counts across all completed quarters.
Number of Prescribers Writing Controlled Substances for Greater than 40% of the Total Prescriptions Written (*Denotes reporting measure unique to opioids)	*9a	Number of prescribers writing controlled substances for greater than 40% of the total prescriptions written of their total written prescriptions in the quarter. For YTD amounts, enter the unduplicated count of unique prescribers included in counts across all completed quarters.
Number of Members Having Filled 3 or More Controlled Substance Prescriptions with at Least 1 CII Prescription (*Denotes reporting measure unique to opioids)	*9b	The total number of members with three or more controlled substance prescriptions in the quarter with at least one CII prescription. For YTD amounts, enter the unduplicated count of unique members included in counts across all completed quarters.

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Column Header	Row #	Description
ER Visits with Pain-Related Diagnosis Codes (*Denotes reporting measure unique to opioids)	*9c	The number of ER visits occurring in the quarter. YTD amounts in this row are auto calculated. ICD 10 codes are reviewed annually for updates, therefore subject to change. Pain codes for current reporting includes the following ICD 10 codes and all codes included under the listed code, unless otherwise specified to be excluded (e.g. pain related to cancer) Include the following codes: • G43-44 (migraines and other headache syndromes), G89 (pain, not otherwise specified, excluding G89.3 neoplasm pain), G90.0 (idiopathic peripheral autonomic neuropathy), G90.5 (complex regional pain syndrome) • M25 (joint disorders), M47-54 (joint and vertebrae pain, other dorsopathies including back pain and cervical/spinal pain), M79 (myalgia and neuralgia), M80-94 (osteopathies) • N94 (pain and other conditions associated with female genital organ) • R07 (throat and chest pain), R10 (abdominal and pelvic pain), R51-52 (headache and unspecified pain), • S00-T88 (Injury, Poisoning, and Certain Other Consequences of External Causes) Exclude members who are: • Receiving hospice or palliative care • Receiving treatment for cancer • Residents of an LTC facility, a facility described in section 1905(d) of Section 1927(g) of the Social Security Act, or another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy
ER Visits with Pain-Related Diagnosis Codes and the Member Received 1 or More Controlled Substance Prescriptions (*Denotes reporting measure unique to opioids)	*9d	Of the ER visits reported in row 9c, the number of occurrences where a member also received one or more controlled substance prescriptions. Limit controlled substance prescriptions to those occurring less than 7 days (< 7) from the date of the ER visit on record. If a member meets the reporting criteria more than once in a quarter, each occurrence should be included in the counts for that quarter. YTD amounts in this row are auto calculated.

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Column Header	Row #	Description
ER Visits with Members Receiving 1 or More Controlled Substance Prescriptions (**Denotes reporting measure unique to non-opioids)	**9e	The number of occurrences where a member had an ER visit and also received one or more controlled substance (non-opioid) prescriptions. Limit controlled substance prescriptions to those occurring less than 7 days (< 7) from the date of the ER visit on record. If a member meets the reporting criteria more than once in a quarter, each occurrence should be included in the counts for that quarter. YTD amounts in this row are auto calculated.

Controlled Substances: Opioids and Non-Opioids By Drug Name

This section if the report captures sorted lists of controlled substance drug names in four different tables:

1. Opioids, CII: Drug Name
2. Opioids, CIII-V: Drug Name
3. Non-Opioids, CII: Drug Name
4. Non-Opioids, CIII-V: Drug Name

In each table, enter the controlled substance drug name in descending order according to count of paid claims with dates of service in the current quarter. When reporting drug names, summarize and rank by generic drug name, not including drug strength or dosage form. For example, Adderall, Adderall XR, and Mydayis ER should all be summarized and ranked as dextroamphetamine/amphetamine.

Do not limit to a set number of drug names when reporting. Report all drugs that are represented in the data in the upper tables, Insert additional rows as needed.

Section XII: Substance Use Disorders

Before entering data in the workbook, ensure that the "Substance Use Disorders" tab is selected. This section of the report captures information regarding utilization of medications used for the treatment of substance use disorder.

This section contains four parts: 1) Opioid / Alcohol Dependence, 2) Nicotine Dependence, 3) Summary – Prior Authorization Request Denials, and 4) Top 5 Reasons For Prior Authorization Request Denials.

Reported amounts are to be based on paid claims with dates of service in the current quarter and previous quarter time periods.

Report based on the most current drug listing(s) (e.g., GPI) that most closely identifies the requested drug category.

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Opioid / Alcohol Dependence

Row Header	Description
Pharmacy Claims Paid (Claims)	The count of paid pharmacy claims for the particular drug. Buprenorphine/Naloxone: Include all Buprenorphine/Naloxone products, brand and generic. Buprenorphine Sublingual: Include all Buprenorphine Sublingual products, brand and generic. Naloxone: Include all Naloxone products, brand and generic.
Pharmacy Claims Paid (Dollars)	The corresponding paid amount for the paid pharmacy claim counts.
Medical Claims Paid (Claims)	**For Naltrexone ER injection only.** The count of paid medical claims (clinic or outpatient hospital) for Naltrexone ER injection.
Medical Claims Paid (Dollars)	**For Naltrexone ER injection only.** The corresponding paid amount for the paid medical claim counts.
Unduplicated Count of Members Receiving a Prescription	The unduplicated count of members receiving at least one prescription for the particular drug.
Unduplicated Count of Members Receiving the Drug	**For Naltrexone ER injection only.** The unduplicated count of members receiving the drug (i.e., prescription or physician-administered claim).
Prior Authorization Requests	The number of prior authorization requests received by the MCO for the particular drug. Prior authorizations should be counted only once per patient, per drug, and per service date. Do not include duplicate prior authorization requests.
Prior Authorization Requests Denied	The number of prior authorization requests that were denied.
Percentage of Prior Authorization Requests Denied	Amounts are auto calculated; data entry is not required.

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Nicotine Dependence

Row Header	Description
Pharmacy Claims Paid (Claims)	The count of paid pharmacy claims for the particular drug. Bupropion: To the extent possible, include only those bupropion prescriptions at the dose for smoking cessation. Nicotine Replacement Therapy: Include all forms of nicotine replacement therapy such as patches, gum, lozenges and spray, both brand and generic as well as both legend and OTC formulations.
Pharmacy Claims Paid (Dollars)	The corresponding paid amount for the paid pharmacy claim counts.
Unduplicated Count of Members Receiving a Prescription	The unduplicated count of members receiving at least one prescription for the particular drug. Bupropion: Include only those bupropion HCL prescriptions for 150mg ER 12-hour tablets administered twice daily. Do not include any other bupropion formulations.
Prior Authorization Requests	The number of prior authorization requests received by the MCO for the particular drug. Prior authorizations should be counted only once per patient, per drug, and per service date. Do not include duplicate prior authorization requests. Bupropion: The actual number of prior authorization requests received by the MCO for bupropion 150mg ER 12-hour tablets.
Prior Authorization Requests Denied	The number of prior authorization requests that were denied.
Percentage of Prior Authorization Requests Denied	Amounts are auto calculated; data entry is not required.

Summary - Prior Authorization Request Denials

This table provides a summary of the prior authorization request denials and denial percentages reported in the Opioid / Alcohol Dependence and Nicotine Dependence tables above. All amounts are auto calculated; data entry is not required.

Top 5 Reasons For Prior Authorization Request Denials

This table provides a summary of the top 5 prior authorization request denial reasons for each drug and the corresponding count of denials. Counts reported in this table are a subset of the total prior authorization request denials reported in the other tables in this section.

Top 5 PA Request Denials

Enter the number of denials associated with each of the top 5 prior authorization request denial reasons.

Top 5 Denial % of Total Denied PA Requests

The percentage of total prior authorization denials for each drug attributable to the denials for each of the top 5 denial reasons. Amounts are auto calculated; data entry is not required.

Top 5 PA Request Denial Reasons

Enter the top 5 prior authorization request denial reasons for each drug in descending order starting with the denial reason with the most denials.

Section XIII: HIV-AIDS Drug Utilization

Before entering data in the workbook, ensure that the "HIV-AIDS Drug Util" tab is selected. This section of the report captures information regarding utilization of HIV-AIDS drugs.

Please refer to the HIV-AIDS Drug List in the addendum for classification of HIV drugs. Note that this template will be modified as new drugs are introduced to or removed from the market. If new drugs have been introduced to the market since the report was last updated, include utilization of the drug in the appropriate drug class. If the drug is the first in a completely new drug class, include the utilization in the miscellaneous antiretroviral combinations category until a new category is created on the template.

Report based on the most current drug listing(s) (e.g., GPI) that most closely identifies the requested drug category.

When the report is submitted each quarter, the data in the previous quarters should be updated to reflect claims submitted and/or paid with dates of service falling into those quarters.

Enter the total unduplicated count of members using at least one HIV-AIDS medication during the quarter and YTD.

Pharmacy Claims Paid for HIV/AIDS

Claims Paid – Claims

For each drug class, enter the number of paid claims for HIV/AIDS medications with dates of service during the applicable time period.

Claims Paid – Dollars

Enter the corresponding dollar amount paid for the claims.

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Average Amount Paid Per Claim

The average dollar amount paid per claim for HIV/AIDS medications. Amounts in this table are auto calculated based on reported claims and dollars; data entry is not required.

Pharmacy Claims Submitted for HIV/AIDS

Enter the count of claims submitted for each drug class. Count only one prescription per patient per medication per date of service, even if the prescription is submitted multiple times.

Pharmacy Claims Denied for HIV/AIDS

Amounts in this table are auto calculated based on reported submitted and paid claims; data entry is not required.

Addendum

HIV-AIDS Drug Category List

Drug Description
1. Antiretroviral Boosting Agent(s)
Cobicistat (CYP3A4 inhibitor)
Ritonavir (protease inhibitor)
2. Cellular Chemokine Receptor Antagonist(s)
Maraviroc
3. Fusion Inhibitors
Enfuvirtide
4. Integrase Inhibitors
Dolutegravir
Elvitegravir
Raltegravir
5. Miscellaneous Antiretroviral Combinations
Abacavir/Dolutegravir/Lamivudine
Atazanavir/Cobicistat
Darunavir/Cobicistat
Darunavir/Cobicistat/Emtricitabine/Tenofovir
Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Alafenamide
Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Disoproxil Fumarate
6. Non-Nucleoside Reverse Transcriptase Inhibitors
Delavirdine Mesylate
Efavirenz
Etravirine
Nevirapine

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HIV-AIDS Drug Category List

Drug Description
Rilpivirine
7. Nucleoside Reverse Transcriptase Inhibitors
Abacavir
Didanosine
Emtricitabine
Lamivudine
Stavudine
Zidovudine
Zalcitabine
8. Nucleotide Analog Reverse Transcriptase Inhibitor(s)
Tenofovir Disoproxil Fumarate
9. Protease Inhibitor Combinations
Lopinavir/Ritonavir
10. Protease Inhibitors
Amprenavir/Vitamin E
Atazanavir
Darunavir
Fosamprenavir
Indinavir
Nelfinavir
Saquinavir
Tipranavir
11. Reverse Transcriptase Combinations
Abacavir Sulfate/Lamivudine/Zidovudine
Abacavir/Lamivudine
Dolutegravir/Lamivudine
Doravirine/Lamivudine/Tenofovir Disoproxil Fumarate
Dolutegravir/Rilpivirine
Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate
Efavirenz/Lamivudine/Tenofovir Disoproxil Fumarate
Emtricitabine/Rilpivirine/Tenofovir Disoproxil Fumarate
Emtricitabine/Rilpivirine/Tenofovir Alafenamide
Emtricitabine/Tenofovir Alafenamide Fumarate
Emtricitabine/Tenofovir Disoproxil Fumarate
Lamivudine/Tenofovir Disoproxil Fumarate
Lamivudine/Zidovudine
12. Post-Attachment Inhibitors
Ibalizumab-uiyk

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Section XIV: Hepatitis C Drug Utilization

Before entering data in the workbook, ensure that the "Hep C Drug Util" tab is selected. This section of the report captures information regarding utilization of Hepatitis C Direct Acting Antiviral drugs. Note that this template will be modified as new drugs are introduced to or removed from the market.

When the report is submitted each quarter, the data in the previous quarters should be updated to reflect claims submitted and/or paid with dates of service falling into those quarters.

Enter the total unduplicated count of members using at least one Hepatitis C Direct Acting Antiviral medication during the quarter and YTD.

Pharmacy Claims Paid – Rows 1 through 12

The template includes all currently available Hepatitis C Direct Acting Antiviral medications. Do not include other medications used for Hepatitis C, such as interferons or ribavirin, in this tab.

Amounts for brand and generic should be entered for each drug, as applicable. Amounts for authorized generics should be reported under generics. Note that drugs with no generic currently available (as of the date these instructions were released) include "(upon availability)" in the generic row header. Amounts should be entered in these rows once generics are available.

Report based on the most current drug listing(s) (e.g., GPI) that most closely identifies the requested drug category.

Note that rows labeled as "Reserved" are locked to prevent data entry and are reserved for future use.

Claims Paid – Claims

Enter the number of paid claims for Hepatitis C Direct Acting Antiviral drugs with dates of service during the applicable time period.

Claims Paid – Dollars

Enter the corresponding dollar amount paid for the claims.

Average Amount Paid Per Claim

The average dollar amount paid per claim for Hepatitis C Direct Acting Antiviral drugs. Amounts in this table are auto calculated based on reported claims and dollars; data entry is not required.