# OVERVIEW OF UNIFORM PREFERRED DRUG LIST (UPDL) MONTHLY REVIEW

## BACKGROUND

In 2014, the Division of Medicaid (DOM) began development of a Uniform Preferred Drug List (UPDL) for use in the Medicaid pharmacy program. The objectives of the UPDL were (1) to make treatment of Medicaid beneficiaries easier for providers by having the same preferred drug list regardless of pharmacy program (fee-for-service or coordinated care plan), (2) to maximize pharmacy rebates to Medicaid in order to reduce to cost of care delivered, and (3) to assure that similar services are provided to Medicaid beneficiaries regardless of health plan. The UPDL was implemented in January 2015 and with coordinated care contracts requiring compliance with the UPDL. Since compliance with a preferred drug list is complicated and changes occur in the UPDL throughout the year, MS-DUR was asked by DOM to add a monthly compliance monitoring program to its contract deliverables. The purpose of the monthly report is to help DOM monitor UPDL compliance and identify problem areas that need to be addressed in any of the three pharmacy programs.

## METHODS AND REPORT SAMPLES

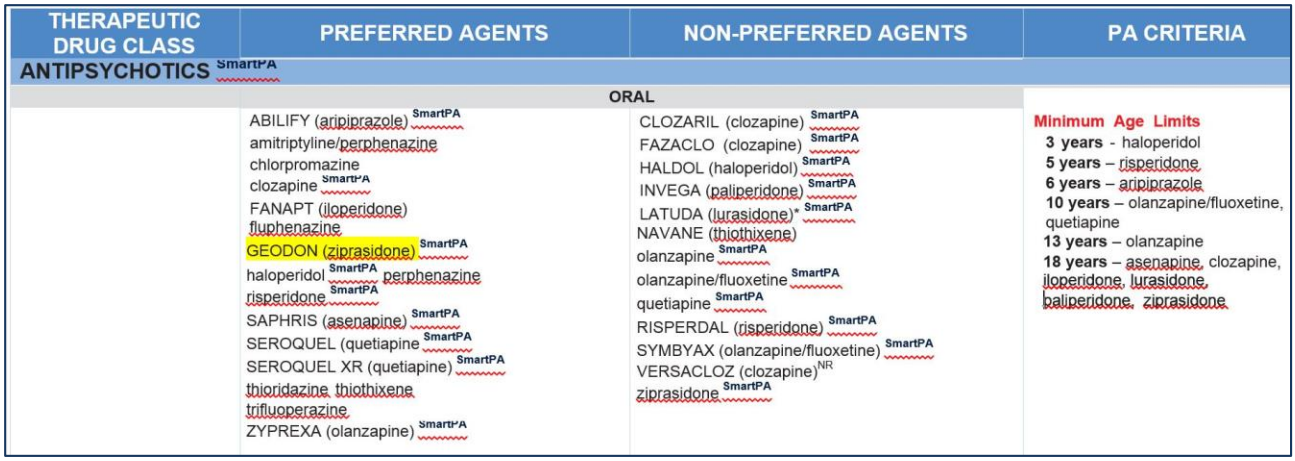
MS-DUR will maintain a database of the monthly preferred/non-preferred status of all products included in the UPDL starting with January 2015. Each month MS-DUR will provide DOM a detailed report summarizing the status of all claims for the products in the UPDL. The Monthly UPDL Compliance Report will include three major tables:

1. A summary of the number of claims and the percent of claims for non-preferred agents for each of the last 3 months broken down by each reviewed category/subcategory of agents in the UPDL.

2. A detailed breakdown for each UPDL category/subcategory identifying preferred/non-preferred use for the prior month by individual agent at the brand/generic, strength and dosing form levels.

3. A summary for the last month for each reviewed category/subcategory of the prior authorization (PA) source for each non-preferred agent used in the FFS program.

Tables 1 and 2 will be reported for each Medicaid pharmacy program (FFS, Magnolia Health Care, and United Health Care). An abbreviated example of how the monthly UPDL Compliance Report will be used by DOM is given below for the oral antipsychotic class. The January 2015 UPDL for this class is shown below.



| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| ANTIPSYCHOTICS SmartPA | | | |
| | ORAL | | |
| | ABILIFY (aripiprazole) SmartPA<br>amitriptyline/perphenazine<br>chlorpromazine<br>clozapine SmartPA<br>FANAPT (iloperidone)<br>fluphenazine<br>GEODON (ziprasidone) SmartPA<br>haloperidol SmartPA perphenazine<br>risperidone SmartPA<br>SAPHRIS (asenapine) SmartPA<br>SEROQUEL (quetiapine SmartPA<br>SEROQUEL XR (quetiapine) SmartPA<br>thioridazine thiothixene<br>trifluoperazine<br>ZYPREXA (olanzapine) SmartPA | CLOZARIL (clozapine) SmartPA<br>FAZACLO (clozapine) SmartPA<br>HALDOL (haloperidol) SmartPA<br>INVEGA (paliperidone) SmartPA<br>LATUDA (lurasidone)* SmartPA<br>NAVANE (thiothixene)<br>olanzapine SmartPA<br>olanzapine/fluoxetine SmartPA<br>quetiapine SmartPA<br>RISPERDAL (risperidone) SmartPA<br>SYMBYAX (olanzapine/fluoxetine) SmartPA<br>VERSACLOZ (clozapine)NR<br>ziprasidone SmartPA | Minimum Age Limits<br>3 years - haloperidol<br>5 years – risperidone<br>6 years – aripiprazole<br>10 years – olanzapine/fluoxetine, quetiapine<br>13 years – olanzapine<br>18 years – asenapine, clozapine, iloperidone, lurasidone, paliperidone, ziprasidone |

Table 1 will be used to identify UPDL categories / subcategories where a larger than expected percentage of non-preferred product use is occurring or where use of non-preferred agents is not consistent across pharmacy programs. The current shift of most children to coordinated care will result in the patient population in the FFS program being somewhat different than that of the two coordinated care plans. This will result in utilization differences between FFS and coordinate care plans for many therapeutic categories. However, utilization that does occur in each therapeutic category should have similar rates of non-preferred agent use across the three programs. The last three months will be reported in order to identify increasing or decreasing trends in non-preferred use. A sample Table 1 based on actual data is shown below for the oral antipsychotic category.

**TABLE 1**
**MISSISSIPPI DIVISION OF MEDICATION PDL COMPLIANCE* REPORT**
**PDL CATEGORY SUMMARY BY PLAN**
**REPORT PERIOD January 2015 - March 2015**
***(EXAMPLE FOR BOARD DISCUSSION ONLY)***

| | | Prescription Plan | | | | | |
|---|---|---|---|---|---|---|---|
| | | FFS | | Magnolia | | UHC | |
| CATEGORY | Month | Total # Claims | % Non-preferred | Total # Claims | % Non-preferred | Total # Claims | % Non-preferred |
| Antipsychotics: Oral | Jan 2015 | 5,654 | 3.5% | 4,917 | 13.5% | 3,203 | 8.9% |
| | Feb 2015 | 6,292 | 3.2% | 3,654 | 13.7% | 3,145 | 4.7% |
| | Mar 2015 | 5,629 | 3.1% | 3,933 | 13.2% | 1,997 | 4.6% |

Non-preferred product use is not always expected to be 0%. In many categories there will be medically acceptable reasons why non-preferred agents are needed. When this occurs, it is expected that PAs will be approved for use of non-preferred products. Use of non-preferred agents will also be expected to occur when a change in preferred status has taken place and use of the previously preferred product is being “grandfathered.” Grandfathering is allowed when DOM has determined that abruptly forcing providers and patients to change to a preferred agent will be

overly disruptive to care. In these cases, patients who have been on stable therapy on the previously preferred product will be allowed to continue on that regimen for a specified period of time or until they need a change in therapy. When grandfathering is allowed, any new starts in therapy will be required to use a preferred agent. When a UPDL change occurs and grandfathering is allowed for the drug product, it will be expected that non-preferred use of the agent will occur immediately after the change in UPDL status, but non-preferred use will decline over time as prescribers have to make changes in therapy for these patients.

When the rate of non-preferred use is considered to be higher than expected, Table 2 will be used to identify the specific products being used by brand/generic status, strength and dosage form. Information in this table will allow MS-DUR and DOM to identify the specific agents resulting in non-preferred product use and to determine what actions are needed, when appropriate, to assure more appropriate compliance with the UPDL. The example section of Table 2 below illustrates how DOM will be able to determine exactly where non-compliance is occurring. Examples of how the information in Table 2 will be used to evaluate the use of non-preferred agents are given below:

- A small number of patients received brand Clozaril instead of the preferred generic of this agent. This occurred in two of the three pharmacy programs. Unless the prescriber has requested a PA for use of the brand for medically necessary reasons, these cases usually will be the result of grandfathering being extended to generic status instead of the agent itself. In therapeutic categories that are considered to be narrow therapeutic index drugs, DOM may decide that grandfathering will be done at the brand/generic level. However, usually this is not the case and use of non-preferred brands is an issue that will need to be address in the PA process.

- In all three pharmacy plans a large number of claims occurred for generic Olanzapine instead of the preferred brand product Zyprexa. Detecting this non-preferred drug use is important since it can result in a significant loss in rebates to DOM. Again, non-preferred product use such as this indicates a problem that needs to be addressed in the adjudication process or PA process.

- Invega moved to non-preferred in January, thus all claims for this product are currently non-preferred. The use currently taking place is an example of grandfathering being allowed when the change in status occurred. MS-DUR and DOM will watch these numbers over time to be sure non-preferred use declines as patients change to other therapies over time.

**TABLE 2**
**MISSISSIPPI DIVISION OF MEDICATION PDL COMPLIANCE* REPORT**
**PDL CATEGORY DRUG LEVEL DETAIL BY PLAN**
**REPORT MONTH March 2015**
***(EXAMPLE FOR BOARD DISCUSSION ONLY)***

| | | | | Prescription Plan | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | FFS | | Magnolia | | UHC | |
| | | | | PDL Status | | PDL Status | | PDL Status | |
| | Form | Product | Strength | Non-preferred | Preferred | Non-preferred | Preferred | Non-preferred | Preferred |
| **Antipsychotics: Oral** | TABLET | CLOZAPINE | 100 MG | | 165 | | 110 | | 109 |
| | | CLOZARIL | | 2 | | | | 3 | |
| | | CLOZAPINE | 200 MG | | 4 | | 9 | | 6 |
| | | CLOZAPINE | 25 MG | | 53 | | 15 | | 10 |
| | | CLOZARIL | | 3 | | | | | |
| | | CLOZAPINE | 50 MG | | 2 | | | | |
| | TABLET | OLANZAPINE | 10 MG | 19 | | 206 | | 39 | |
| | | ZYPREXA | | | 272 | | 23 | | 160 |
| | | OLANZAPINE | 15 MG | 3 | | 151 | | 29 | |
| | | ZYPREXA | | | 110 | | 10 | | 92 |
| | | OLANZAPINE | 20 MG | 22 | | 310 | | 62 | |
| | | ZYPREXA | | | 142 | | 18 | | 176 |
| | TABLET | QUETIAPINE FUMARATE | 25 MG | | | 10 | | | |
| | | SEROQUEL | | | 342 | | 93 | | 101 |
| | | QUETIAPINE FUMARATE | 50 MG | | | 17 | | 1 | |
| | | SEROQUEL | | | 699 | | 180 | | 268 |
| | | QUETIAPINE FUMARATE | 100 MG | 1 | | 45 | | 3 | |
| | | SEROQUEL | | | 765 | | 597 | | 361 |
| | | QUETIAPINE FUMARATE | 200 MG | 4 | | 39 | | | |
| | | SEROQUEL | | | 463 | | 476 | | 385 |
| | TABLET, EXTENDED RELEASE | INVEGA | 1.5 MG | 9 | | 3 | | | |
| | | INVEGA | 3 MG | 21 | | 28 | | 16 | |
| | | INVEGA | 6 MG | 43 | | 99 | | 40 | |
| | | INVEGA | 9 MG | 42 | | 57 | | 45 | |