DUR Board Meeting
September 17, 2012
Hilton Garden Inn
4351 17th Avenue South
Fargo, ND

North Dakota Medicaid
DUR Board Meeting Agenda
Hilton Garden Inn
4351 17th Avenue South
Fargo, ND
September 17, 2012
1pm

1. Administrative items
    - Travel vouchers

2. Old business
    - Review and approval of 06/12 meeting minutes — Chair
    - Budget update — Brendan
    - Second review of Kalydeco — Brendan
    - Second review of Kuvan — Brendan
    - Second review of Elaprase — Brendan
    - SSRI/SNRI Update — Brendan
    - Topical Steroids Update — Brendan
    - Yearly PA review — HID
        - DAW
        - Amrix/Fexmid
        - Xenical
        - Zanaflex caps
        - Ketek
        - Aczone
        - Topical Ketoconazole
        - Clorpres
        - Gilenya
        - Livalo
        - Oravig
        - Xyrem
        - Zyclara
        - Nuedexta
        - Nexiclon
        - Narcotic/APAP combo products

3. New business
    - Review of Actinic Keratosis — HID
    - Review of Moxeza — HID
    - Review of Lidoderm — HID
    - Review of Patients Taking Suboxone — HID
    - Review of Patients Taking Multiple Long-Acting Narcotics — HID
    - Criteria recommendations — HID
    - Upcoming meeting date/agenda — Chair

4. Adjourn — Chair

Please remember to silence all cellular phones and pagers during the meeting.

Drug Utilization Review (DUR) Meeting Minutes
June 4, 2012

Members Present: Norman Byers, John Savageau, Russ Sobotta, Cheryl Huber, Greg Pfister, Tanya Schmidt, Carrie Sorenson, Leann Ness, Carlotta McCleary, David Clinkenbeard, Steve Irsfeld
Members Absent: Kim Krohn, James Carlson, Jeffrey Hostetter, Todd Twogood
Medicaid Pharmacy Department: Brendan Joyce, Gary Betting
HID Staff Present: Candace Rieth

Chair G. Pfister called the meeting to order at 1:00 pm. Chair G. Pfister asked for a motion to approve the minutes from the March meeting. N. Byers moved that the minutes be approved and C. Huber seconded the motion. Chair G. Pfister called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Budget Update
B. Joyce informed the board members that the spend to pharmacies is within pennies of what was projected. Currently, the rebate dollars are fairly significant although the 100% federal match for line extension drug rebates has not been taken out to give the department a net-net total.

Lorzone Second Review
A motion and second were made at the March meeting to place Lorzone on prior authorization. The topic was brought up for a second review. There was no public comment. After discussion, Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Provigil Second Review
A motion and second were made at the March meeting to place Provigil on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Kapvay Second Review
A motion and second were made at the March meeting to place Kapvay on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Dexpak/Zemapak Second Review
A motion and second were made at the March meeting to place Dexpak and Zemapak on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Xifaxan Second Review
A motion and second were made at the March meeting to place Xifaxan on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Vanos Second Review
A motion and second were made at the March meeting to place Vanos on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Yearly PA Review
The Board reviews products annually that have previously been placed on prior authorization. This allows the Board a chance to update the prior authorization forms and criteria. Sedative/Hypnotics, Qualaquin, ACE-I/ARBs/Renin Inhibitors, Synagis, GH/IGF1, and Triptans were reviewed. No changes were made to the forms and criteria.

Topical Corticosteroid Review
B. Joyce reviewed topical corticosteroid information with the Board. There was no public comment. After discussion, N. Byers suggested a dermatologist be consulted. The consult information will be provided at a later date.

Kalydeco Review
B. Joyce reviewed Kalydeco information with the Board. There was no public comment. After discussion, N. Byers made a motion to place Kalydeco on prior authorization for FDA approved indication and to require a CF mutation test. J. Savageau seconded the motion. This topic will be brought up at the next meeting for finalization.

Kuvan Review
B. Joyce reviewed Kuvan information with the Board. There was no public comment. After discussion, C. Huber made a motion to place Kuvan on prior authorization for FDA approved indication. C. Sorenson seconded the motion. This topic will be brought up at the next meeting for finalization.

Elaprase Review
B. Joyce reviewed Elaprase information with the Board. There was no public comment. After discussion, N. Byers made a motion to place Elaprase on prior authorization. C. Sorenson seconded the motion. This topic will be brought up at the next meeting for finalization.

Rescue Inhaler Review
B. Joyce discussed rescue inhaler overutilization with the Board. There is a population of recipients taking rescue inhalers that are using >12 puffs a day. The state would like to get the Board's advice on this trend. A suggestion was made to send an educational letter, with a survey requesting diagnosis information, to prescribers of recipients overutilizing rescue inhalers.

Criteria Recommendations
The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and usually are consistent with new indications, new drugs added, new warnings, etc. These proposed criteria will be added to the current set of criteria, and will be used in future DUR cycles. C. Huber moved to approve the new criteria and N. Byers seconded the motion. Chair G. Pfister called for a voice vote. The motion passed with no audible dissent.

The next DUR board meeting will be held September 17th, 2012 in Fargo. G. Pfister made a motion to adjourn the meeting. C. Sorenson seconded. The motion passed with no audible dissent. Chair G. Pfister adjourned the meeting at 2:00 p.m.

KALYDECO PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Kapvay must meet the following criteria:

- **Patient must have a G551D mutation in the cystic fibrosis conductance regulator (CFTR) gene.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KALYDECO	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

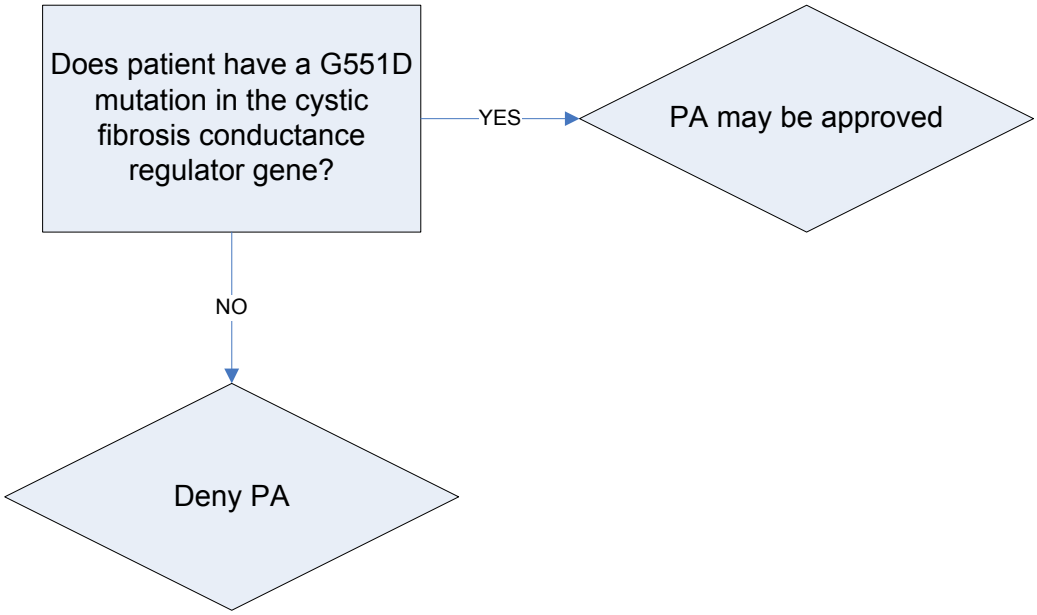
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Kalydeco Prior Authorization Algorithm



KUVAN PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Kuvan must meet the following criteria:

- **Patient must have hyperphenalaninemia.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KUVAN	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

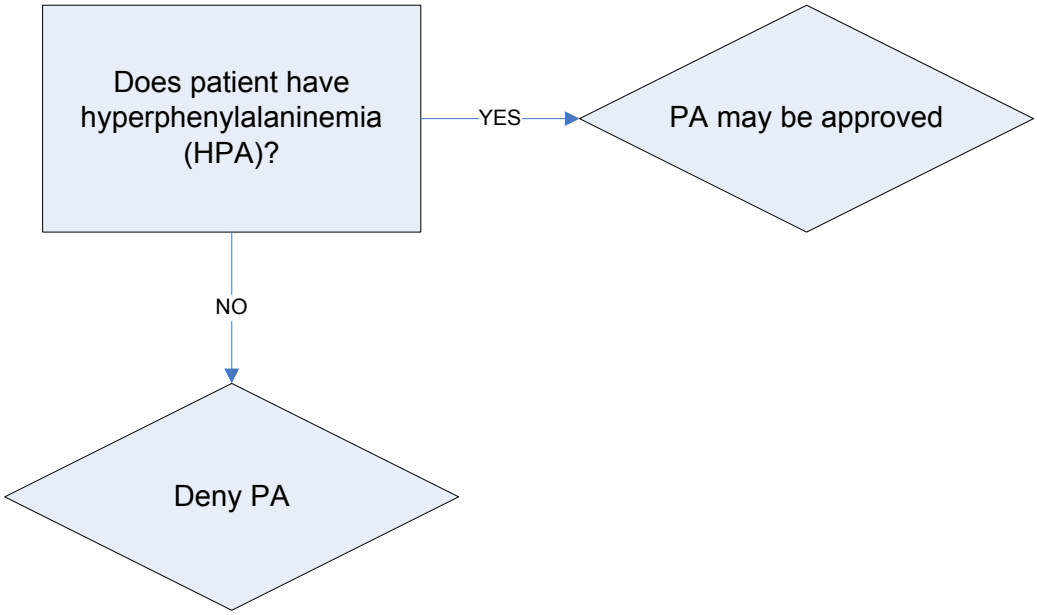
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Kuvan Prior Authorization Algorithm



ELAPRASE PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Elaprase must meet the following criteria:

- **Patient must have Hunter Syndrome.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ELAPRASE	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

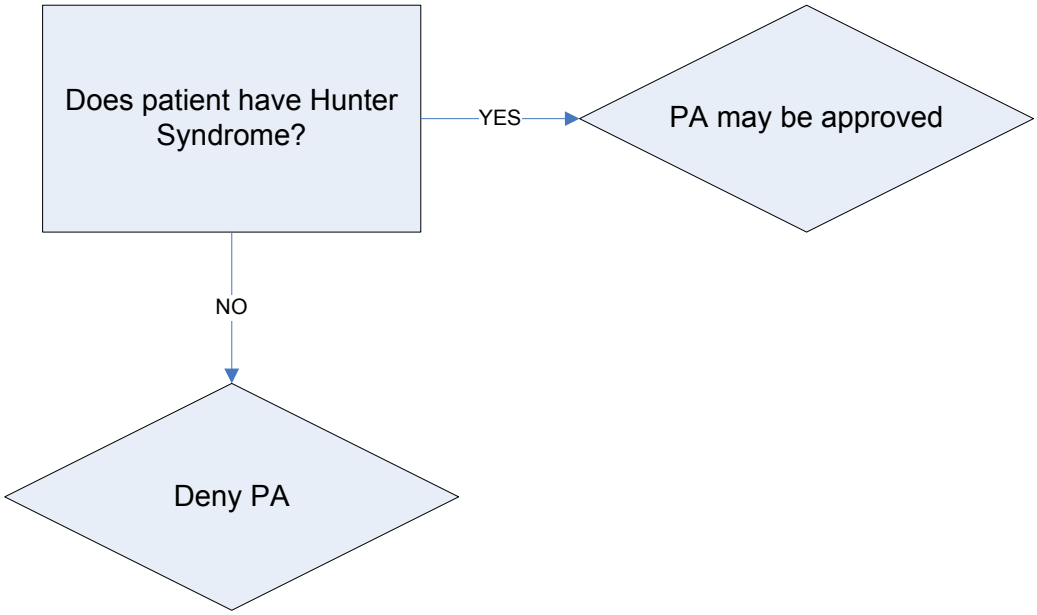
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Elaprase Prior Authorization Algorithm



DISPENSE AS WRITTEN PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

North Dakota Medicaid requires that patients receiving a brand name drug, when there is a generic equivalent available, must first try and fail the generic product for one of the following reasons.

- **The generic product was not effective (attach MedWatch form)**
- **There was an adverse reaction with the generic product (attach MedWatch form)**
- **DAW not allowed for drugs with an authorized generic available.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name				
Prescriber Medicaid Provider Number		Telephone Number	Fax Number	
Address		City	State	Zip Code
Requested Drug:	**DOSAGE:**	**Diagnosis for this request:**		

QUALIFICATIONS FOR COVERAGE: □ FAILED GENERIC EQUIVALENT**(ATTACH FDA MEDWATCH FORM)**	**Start Date**	**End Date**	**Dose**	**Frequency**

ADVERSE REACTION TO GENERIC EQUIVALENT (ATTACH FDA MEDWATCH FORM)
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

AMRIX PA Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients try and fail generic cyclobenzaprine.

**Note:*

- **Cyclobenzaprine does not require PA**
- **Patient must fail therapy on generic cyclobenzaprine before a PA will be considered for Amrix.**

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG:	**Requested Dosage:** (must be completed)

Qualifications for coverage:

❑ Failed cyclobenzaprine therapy	Start Date:	Dose:
	End Date:	Frequency:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber Signature: Date:

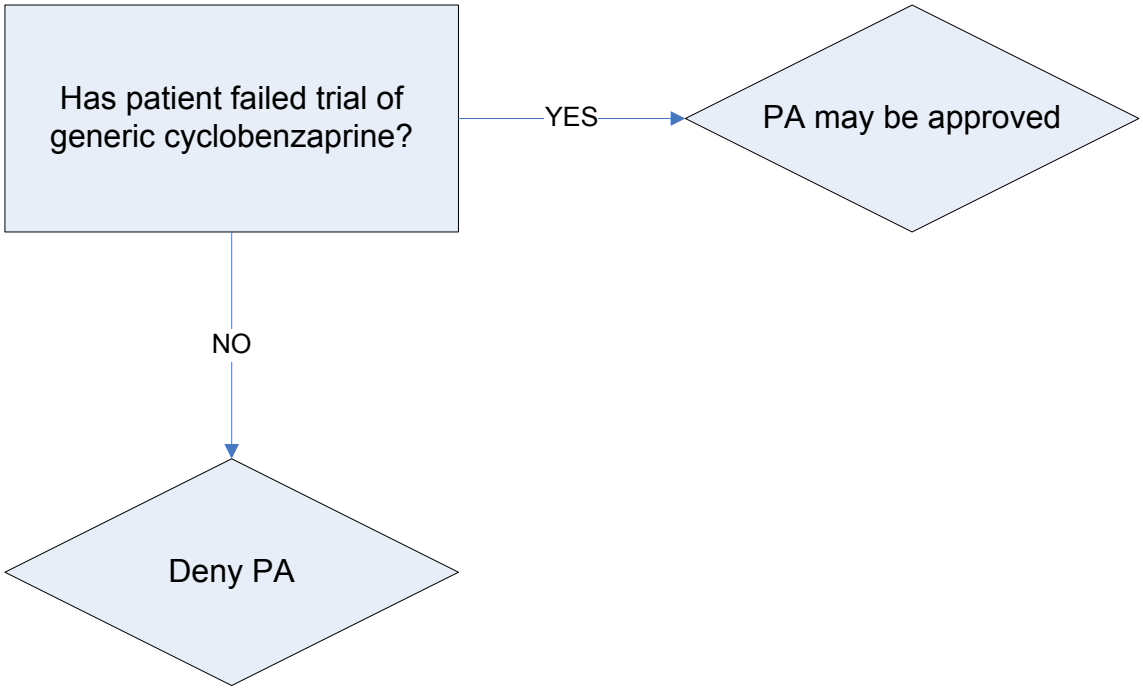
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

North Dakota Department of Human Services
Amrix Authorization Algorithm



HEALTH INFORMATION DESIGNS

Xenical Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a prescription for Xenical must be seen by a dietician.
Note:

- ***Patient must have dietician evaluation attached to PA form including height and weight.***
- ***BMI must be equal to or greater than 40.***
- ***5% weight loss must be realized for continued approval (every 6 months).***

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ XENICAL	**Diagnosis for this request:**		

Qualifications for coverage:			
□ Dietician evaluation attached	Height:	Weight:	BMI:
Prescriber Signature		Date	

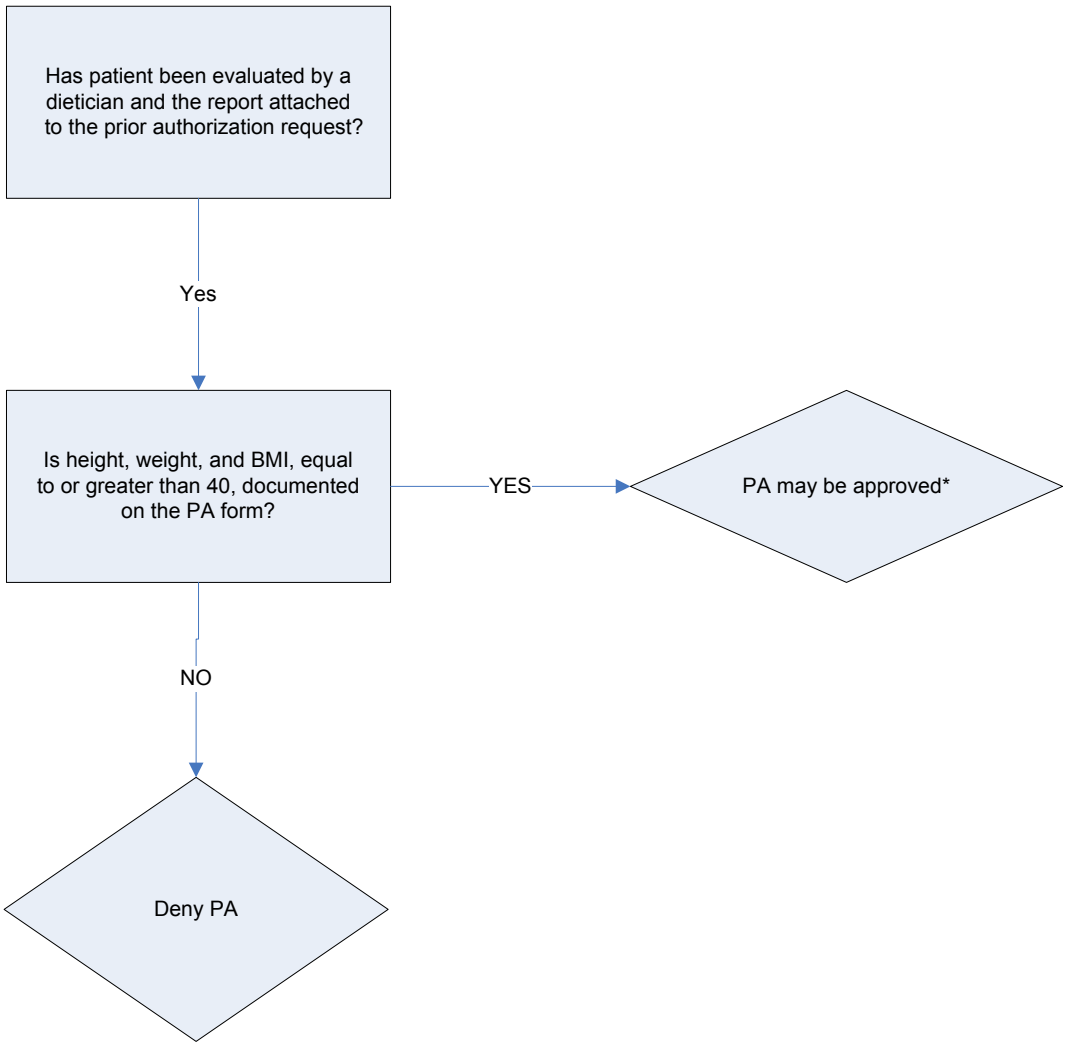
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Xenical Prior Authorization Criteria



*5% weight loss must be realized for continued approval every 6 months.

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Zanaflex Capsule PA Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving Zanaflex capsules must use tizanidine tablets first line.
__Note:__

- **Tizanidine tablets do not require a PA.**
- **Patient must fail therapy on tizanidine tablets before a PA may be granted.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Failed generic drug	Start Date: End Date:	Dose: Frequency:	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

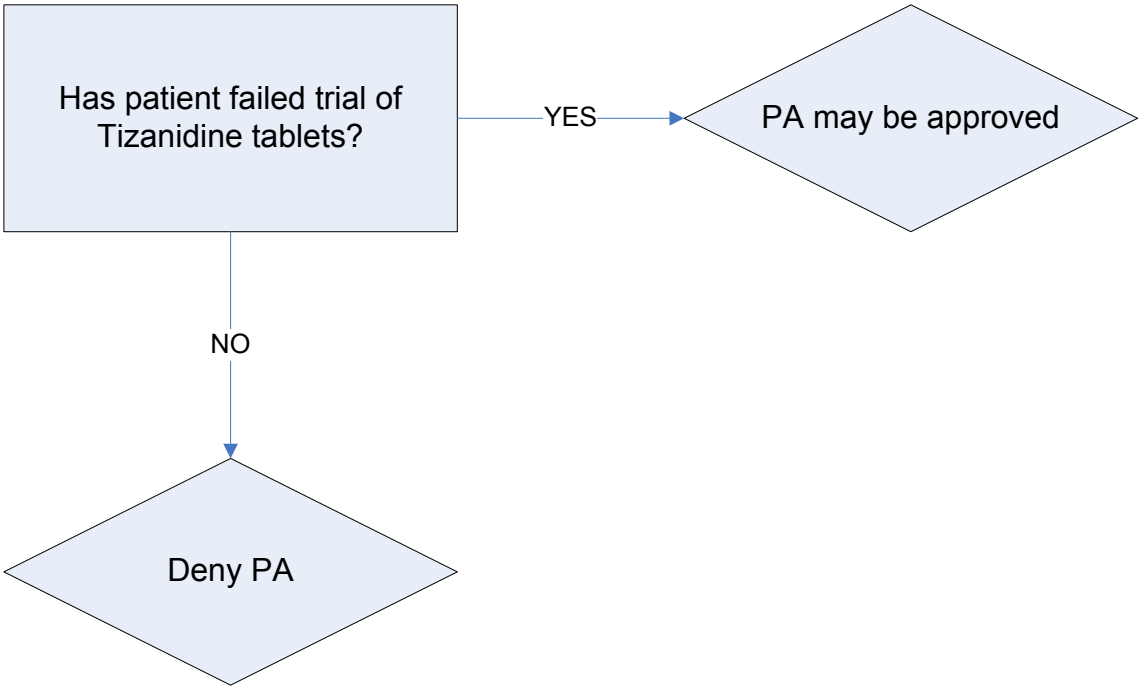
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Zanaflex Authorization Algorithm



HEALTH INFORMATION DESIGNS

KETEK PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

- ND Medicaid will cover Ketek with a diagnosis of community-acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae for patients 18 years and older.
- ND Medicaid will cover Ketek for patients with an allergy to fluoroquinolones or tetracyclines.

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG: □ **KETEK**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

□ Community acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae, (including multi-drug resistant isolates, Haemophilus influenzae, Moraxella catarrhalis, Chlamydophila pneumoniae, or Mycoplasma pneumoniae) for patients 18 years and older.

□ Please list fluoroquinolone or tetracycline that patient is allergic to: _____

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber Signature: Date:

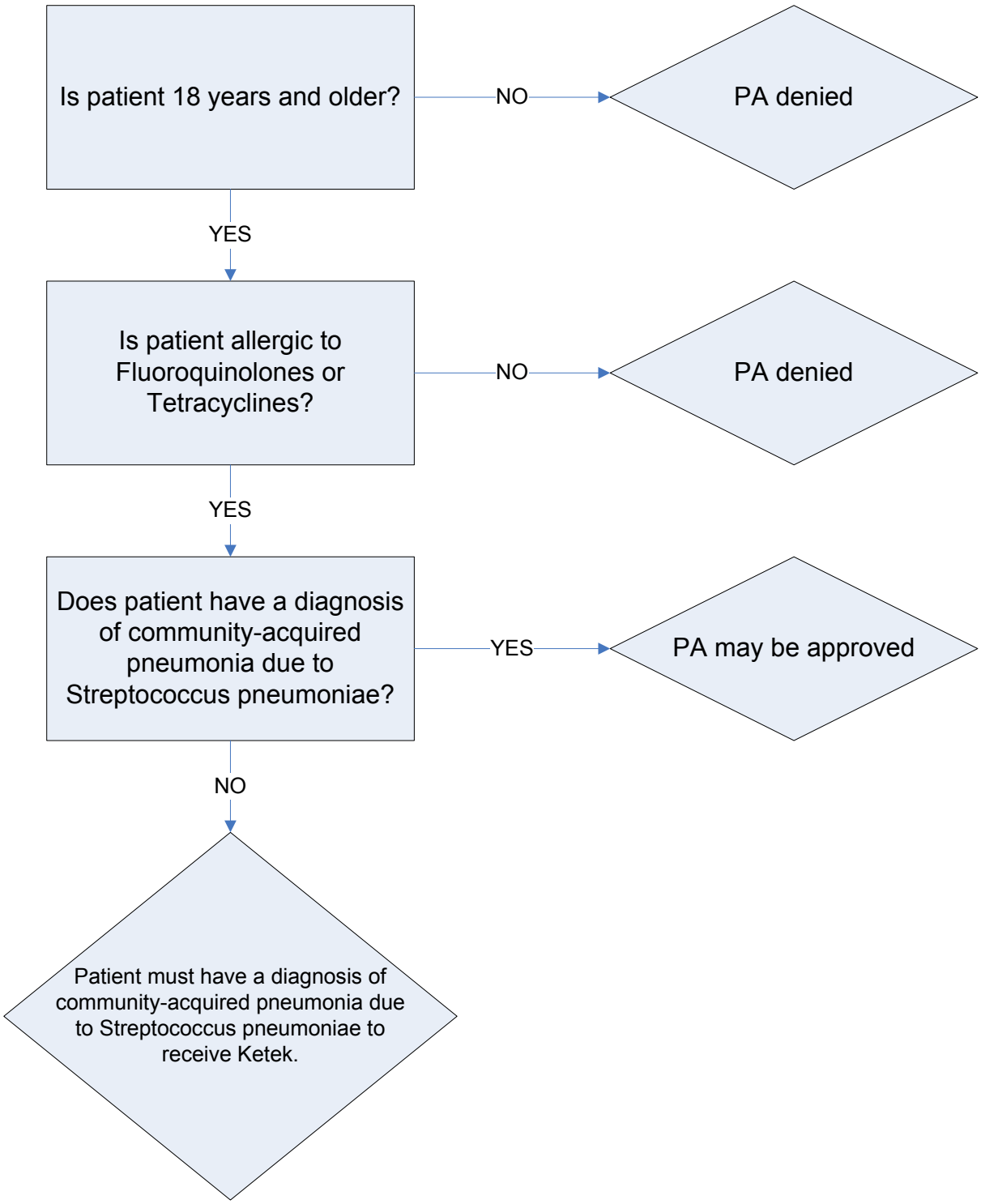
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

North Dakota Department of Human Services
Ketek Criteria Algorithm



Aczone Gel PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Aczone gel must try other topical acne agents as first line therapy.

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ACZONE GEL	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed acne therapy Name of medication failed: _____	Start Date	End Date	Dose	Frequency

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber Signature	Date

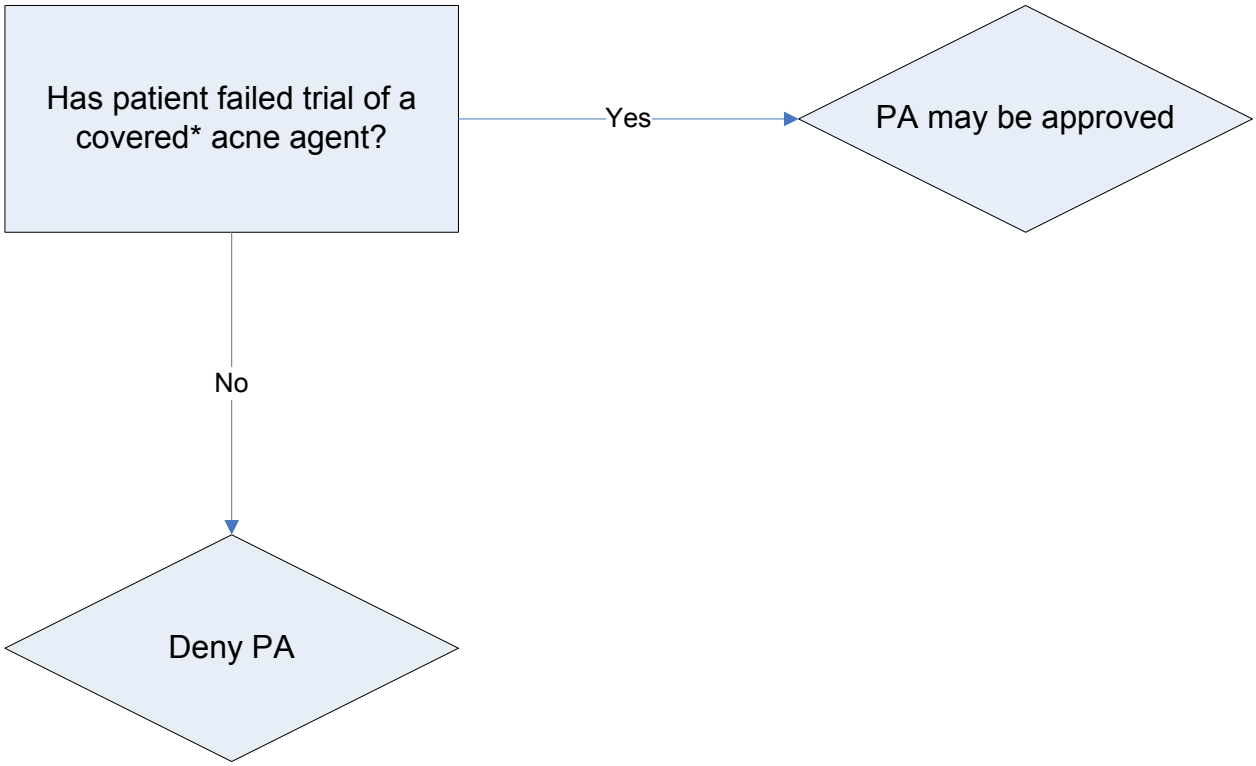
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Aczone Authorization Algorithm



*Tretinoin and benzoyl peroxide products do not require a PA

Topical Ketoconazole Products
Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Extina, Xolegel, and Ketocon Plus must first try a covered ketoconazole medication.

Note:

- ***Ketoconazole creams and ketoconazole shampoos do not require a prior authorization.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Extina** □ **Xolegel** □ **Ketocon Plus**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

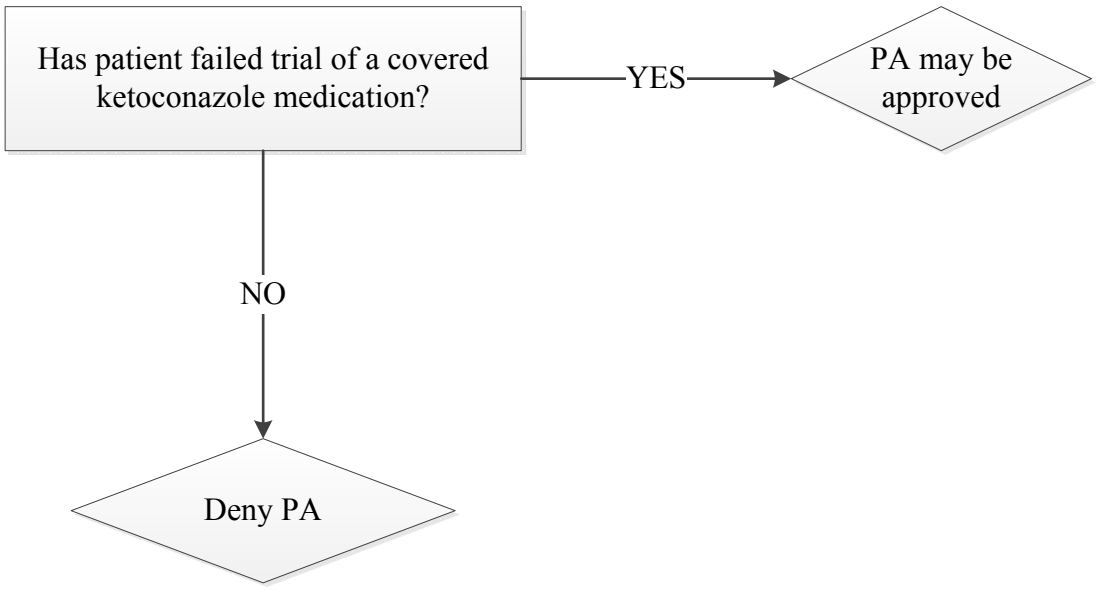
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Topical Ketoconazole Products Authorization Algorithm



Clorpres Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receive clonidine and chlorthalidone separately.
Note:

- ***Clonidine does not require PA***
- ***Chlorthalidone does not require PA***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Clorpres**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Failed both drugs separately	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

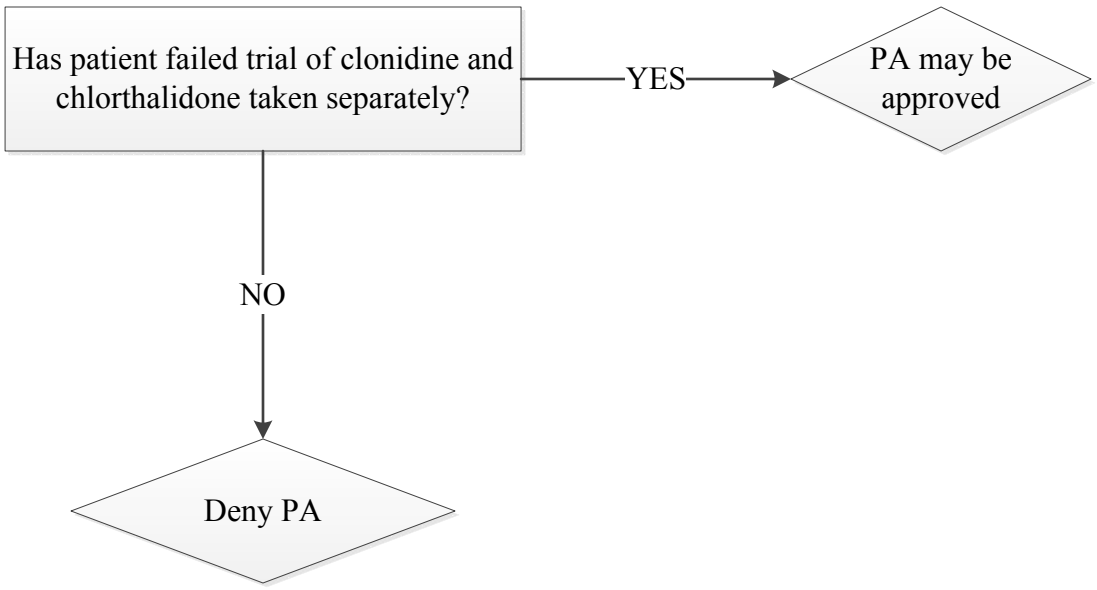
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Clorpres Authorization Algorithm



HEALTH INFORMATION DESIGNS

Gilenya Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Gilenya must follow these guidelines:

***Note:**

- ***Must have relapsing forms of multiple sclerosis.***
- ***Must have a current electrocardiogram (within 6 months) for patients taking anti-arrhythmics, beta-blockers, or calcium channel blockers; patients with cardiac risk factors; and patients with a slow or irregular heart beat.***
- ***Must have a recent CBC (within 6 months).***
- ***Must have an adequate ophthalmologic evaluation at baseline and 3-4 months after treatment initiation.***
- ***Must have recent (within 6 months) transaminase and bilirubin levels before initiation of therapy.***
- ***Will not be approved for use in combination therapy***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Gilenya**	**Diagnosis for this request:**		
Qualifications for coverage:			
Current electrocardiogram **Date:**	**Current CBC** **Date:**	**Ophthalmologic Evaluation** **Date:**	**Transaminase/Bilirubin levels** **Date:**
Physician Signature			Date

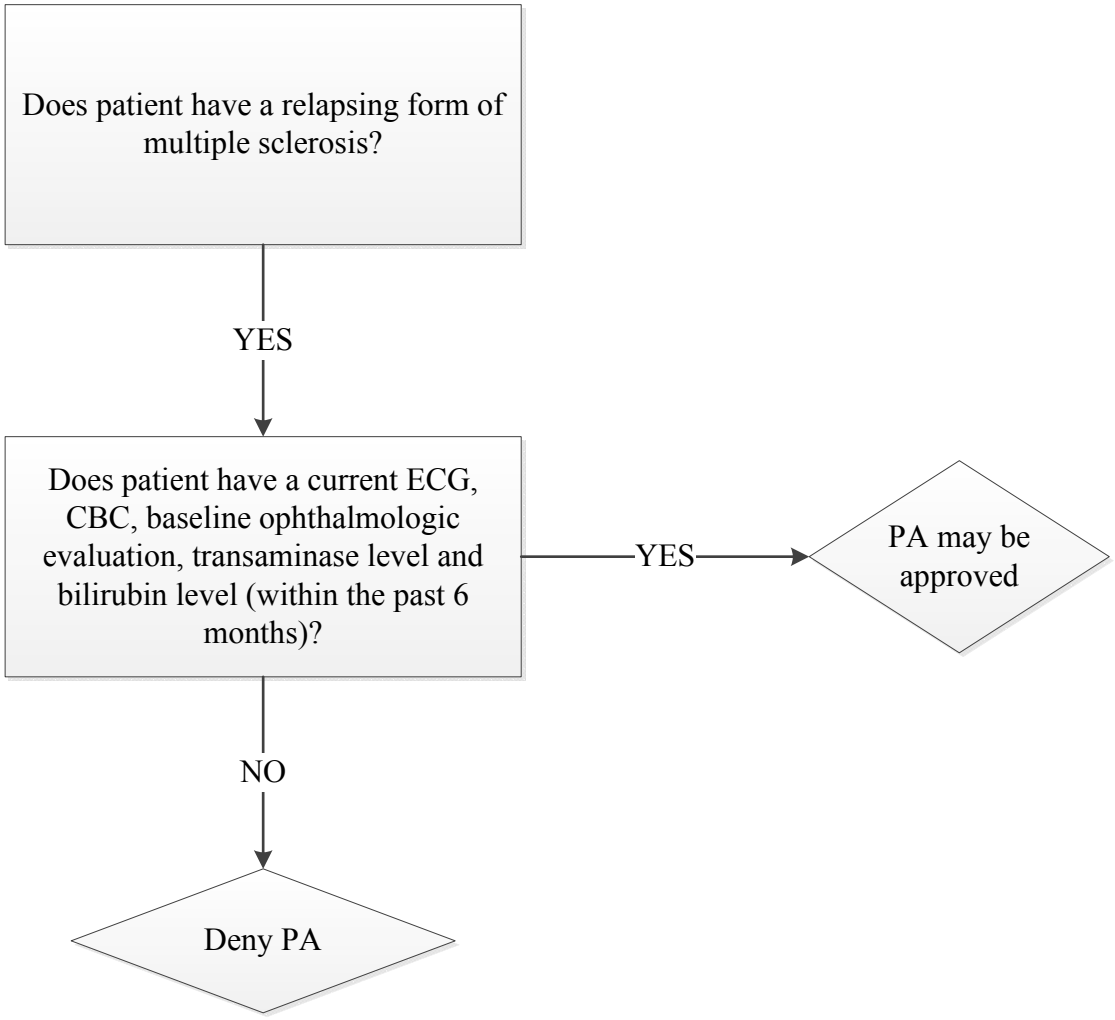
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Gilenya Authorization Algorithm



Livalo Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Livalo must first try a covered statin medication
Note:

- ***Statins already on the market do not require a prior authorization***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Livalo**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

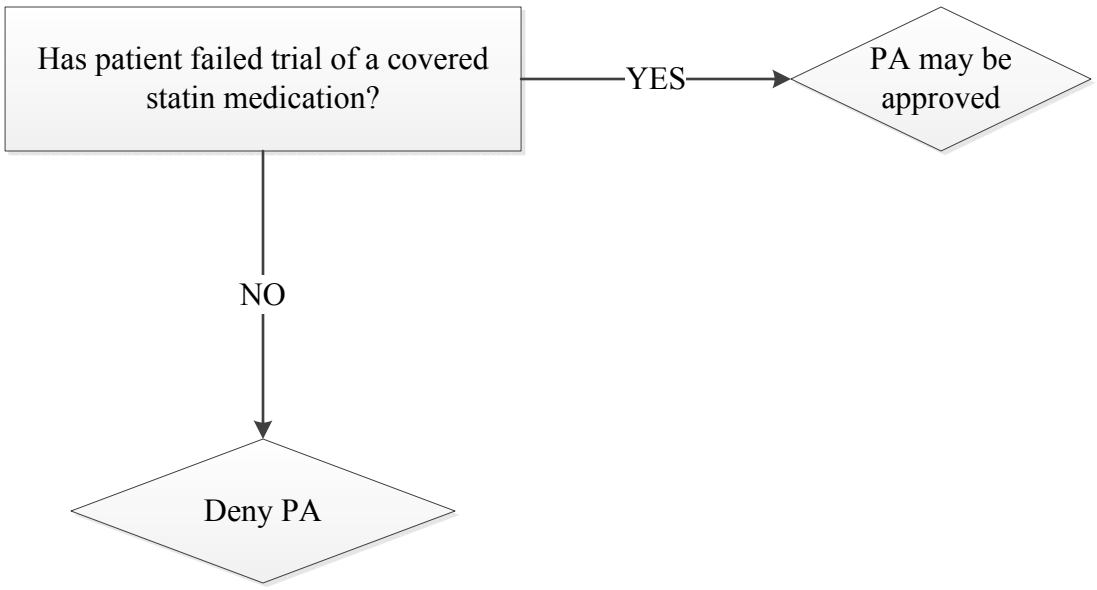
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Livalo Authorization Algorithm



Oravig Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a prescription for Oravig first try fluconazole.
Note:

- ***Fluconazole does not require PA***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Oravig**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ **Medication failed** _____	**Start Date:** **End Date:**	**Dose:** **Frequency:**	
Physician Signature		Date	

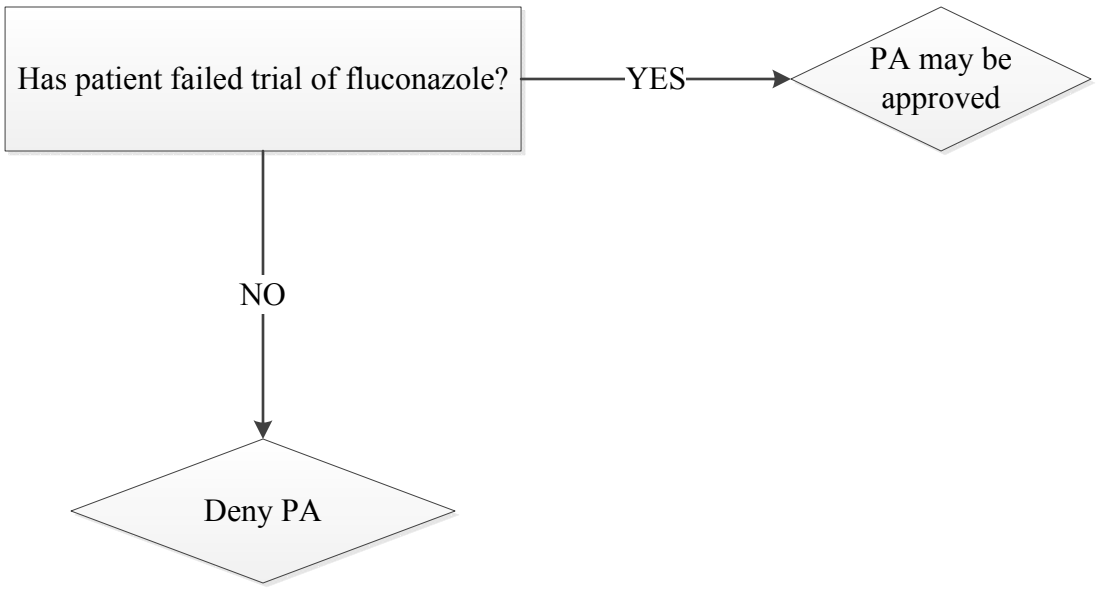
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Oravig Authorization Algorithm



Xyrem Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Xyrem must meet these guidelines:
Note:

- ***Must be 18 years or older.***
- ***Must have a diagnosis of excessive daytime sleepiness and cataplexy in patients with narcolepsy.***
- ***Must be enrolled in the Xyrem Success Program***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Xyrem**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Enrolled in Xyrem Success Program	Enrolled Date:	Dose:	
Physician Signature		Date	

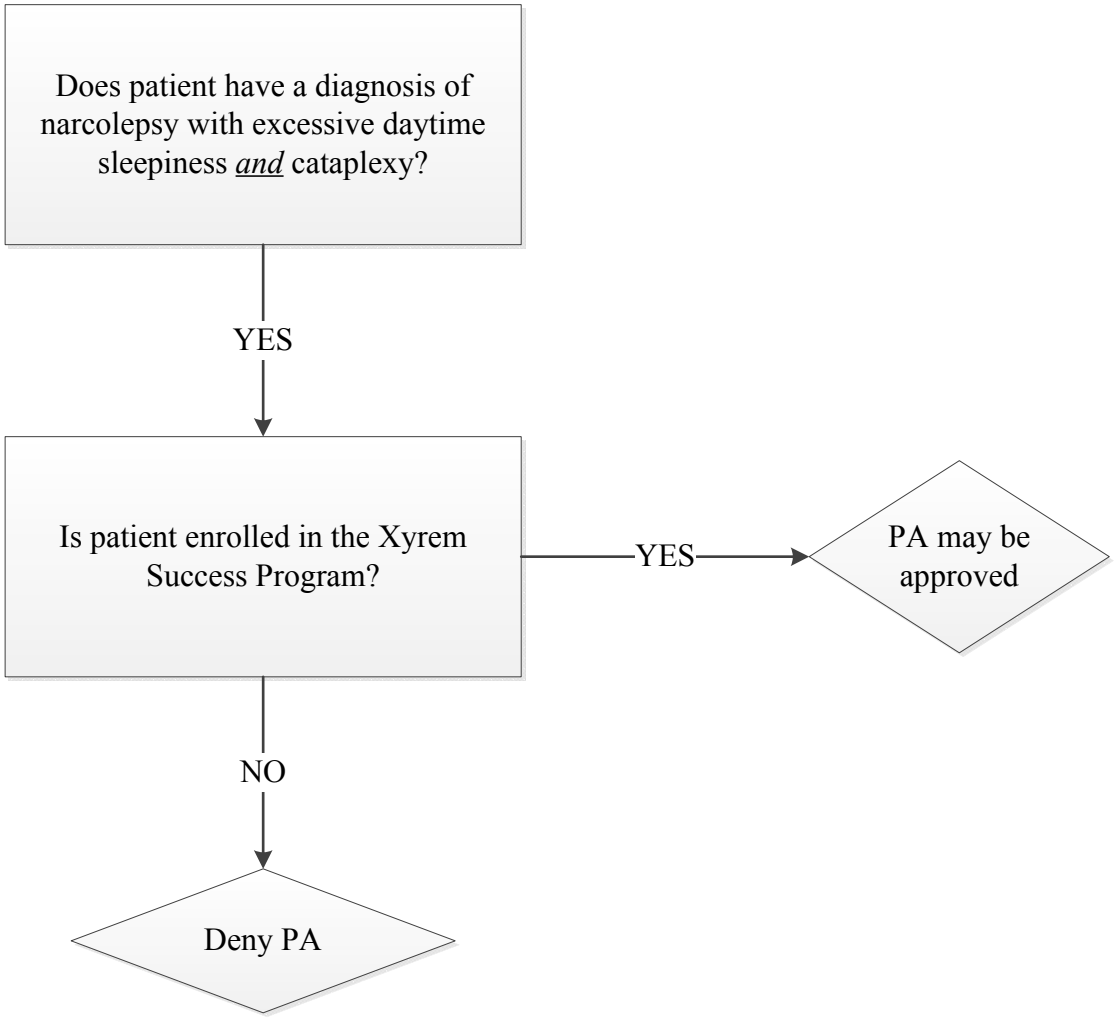
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Xyrem Authorization Algorithm



Zyclara Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a prescription for Zyclara first try imiquimod.
Note:

- ***Imiquimod does not require PA***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Zyclara**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ **Trial of imiquimod** **Start Date** **End Date**			
Physician Signature	Date		

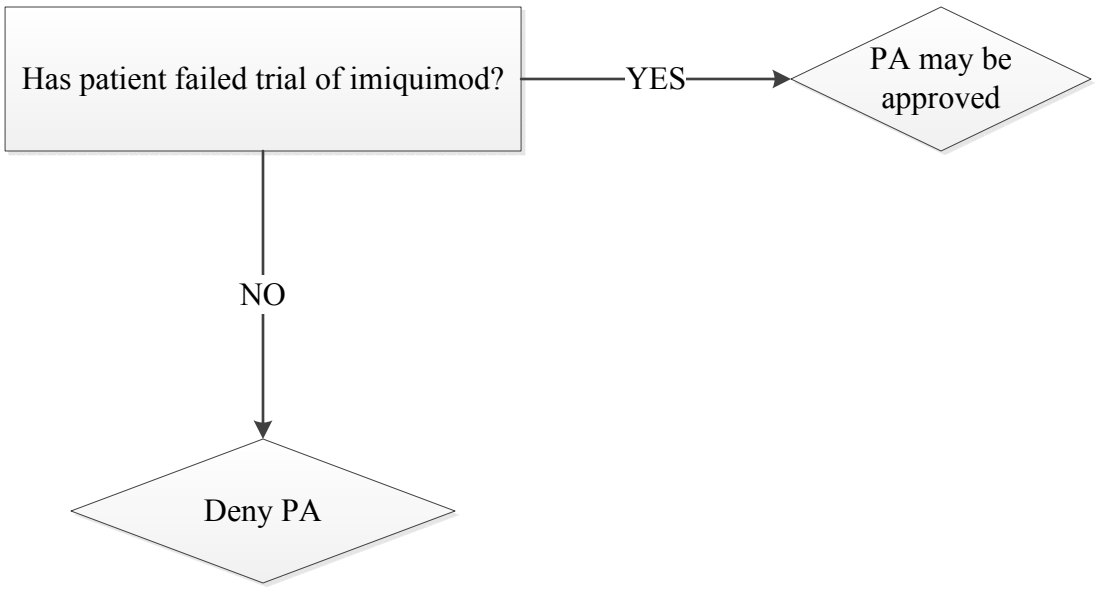
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Zyclara Authorization Algorithm



Nuedexta Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Nuedexta must have a diagnosis of amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS) and exhibit signs of pseudobulbar affect.

Note:

- ***Nuedexta is indicated for the treatment of pseudobulbar affect (PBA).***
- ***Nuedexta has not been shown to be safe or effective in other types of emotional lability that can commonly occur, for example, in Alzheimer's disease and other dementias.***
- ***Nuedexta is contraindicated in patients with a prolonged QT interval, heart failure, or complete atrioventricular (AV) block.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Nuedexta**	**Diagnosis for this request (must check at least 2):** □ **PBA** □ **ALS** □ **MS**		
Physician Signature		Date	

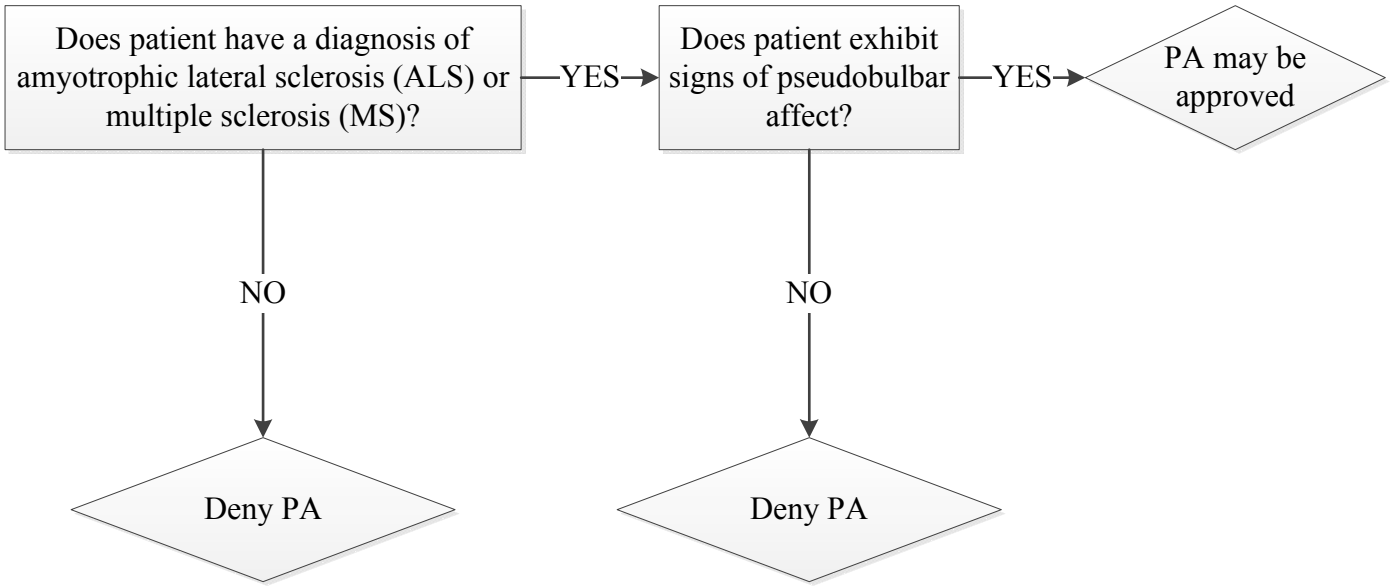
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Nuedexta Authorization Algorithm



Nexiclon Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Nexiclon must try and fail clonidine.
Note:

- ***Clonidine does not require PA***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Nexiclon**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED CLONIDINE THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

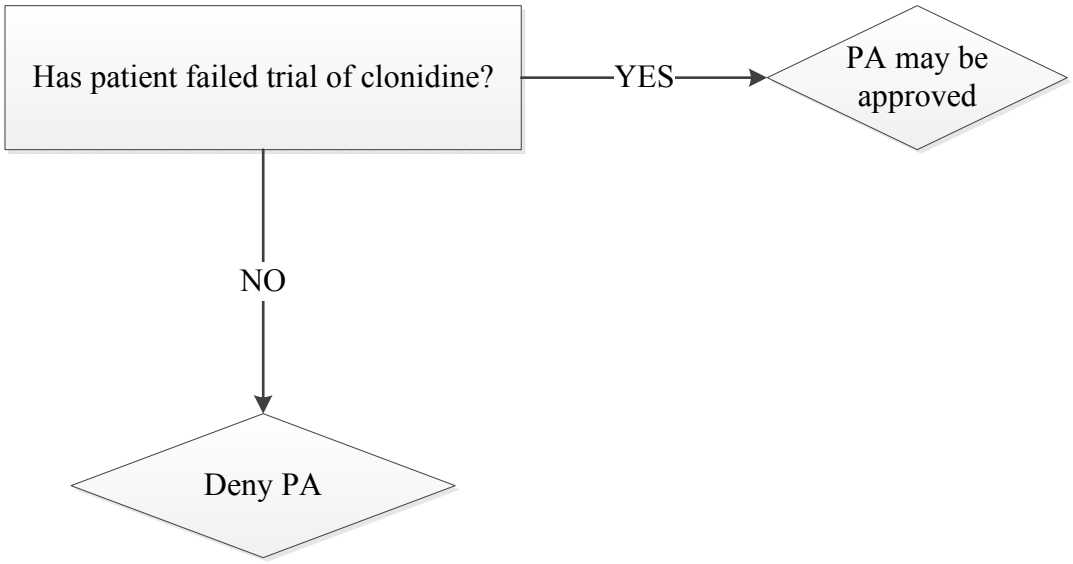
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Nexiclon Authorization Algorithm



Narcotics/APAP
Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for narcotics containing acetaminophen doses greater than 325mg must use hydrocodone/acetaminophen 5/325-10/325 or oxycodone acetaminophen 5/325-10/325.

- ***FDA is requesting that drug manufacturers limit the amount of acetaminophen in prescription drug products to 325mg per dosage unit.***
- ***Higher-dose formulations of hydrocodone/acetaminophen and oxycodone/acetaminophen should be phased out by 2014.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Medicaid
DUR Board Meeting
Actinic Keratoses

Actinic keratoses (AK) are small, rough, raised areas found on sun-damaged skin. Lesions are usually found on the face, scalp, back of hands, chest, or other sun-exposed areas. Symptoms begin as flat scaly areas that may be gray, pink, or red. Often, there is a white or yellow crusty 'scale' on top. Over time, the area develops a hard and wart-like or gritty surface that is sometimes easier to feel than see. In some cases, lesions can potentially progress to squamous cell carcinoma. Ablative therapies (e.g., laser ablation, curettage, cryosurgery, surgery) are generally used in patients with individual or single lesions, whereas topical therapies are generally preferred in patients with multiple lesions. Several topical therapies are available for the treatment of AK and a new agent, Picato, was recently approved. A comparison of the agents used to treat AK is included in the table below.

Product/Cost	Indication/Dosage	Mechanism of Action
Diclofenac Sodium 3% gel (Solaraze) $590/100 gm	Topical treatment of actinic keratoses: Apply to lesion areas twice daily for 60-90 days.	The exact mechanism of action is unknown.
Fluorouracil 0.5% cream (Carac) $339/30 gm	Topical treatment of multiple actinic or solar keratoses of the face and anterior scalp: Apply once daily for up to 4 weeks as tolerated. Do not apply near the eyes, nostrils, or mouth.	Blocks the methylation reaction of deoxyuridylic acid to thymidylic acid, which interferes with the synthesis of DNA, and to a lesser extent, inhibits the formation of RNA. The effect of fluorouracil may be to create a thymine deficiency that provokes unbalanced growth and death of the cell.
Fluorouracil 5% cream and solution and 2% solution (Efudex)-generic available 5% cream: $239/40 gm 5% solution: $83/10 ml 2% solution: $56.10/10 ml	Treatment of actinic keratoses: Apply cream or solution in an amount sufficient to cover the lesions twice daily. Discontinue when inflammatory response reaches the erosion stage. The usual duration of therapy is from 2 to 4 weeks.	
Fluorouracil 1% cream (Fluoroplex) $351/30 gm	Treatment of multiple actinic keratoses: Cover entire face or other affected areas twice daily for 2 to 6 weeks. Discontinue use when inflammatory reaction reaches the erosion, ulceration, and necrosis stages.	
Imiquimod 5% cream (Aldara)-generic available $553/24 packets *treatment requires 32 packets for 16 weeks	Treatment of clinically typical, nonhyperkeratotic, nonhypertrophic actinic keratoses on the face or scalp in immunocompetent adults: Apply up to one packet to the defined treatment area (i.e., 5 cm x 5 cm) of the face or scalp (but not both concurrently) two days per week at bedtime (e.g., Mon. and Thurs. or Tue. and Fri.) for 16 weeks. Wash off after 8 hours.	Exact mechanism of action is unknown. Imiquimod is an immune response modifier that stimulates local cytokine induction, which may result in indirect antineoplastic potency.

Product/Cost	Indication/Dosage	Mechanism of Action
Imiquimod 3.75% cream (Zyclara) 3.75% cream: $646/28 packets 3.75% pump: $707/7.5 gm	Treatment of clinically typical, visible, or palpable actinic keratoses of the face or balding scalp in immunocompetent adults: Once daily to the skin of the affected area for two 2-week treatment cycles separated by a 2-week no treatment period. Treatment of external genital and perianal warts/condyloma acuminata (EGW) in patients 12 years or older: Once daily to the external genital/perianal warts until total clearance or up to 8 weeks.	Exact mechanism of action is unknown. Imiquimod is an immune response modifier that stimulates local cytokine induction, which may result in indirect antineoplastic potency.
Ingenol Mebutate 0.015% and 0.05% gel (Picato) $637/3 unit dose tubes of 0.015% gel $637/2 unit dose tubes of 0.05% gel **Keep refrigerated at 36-45 degrees.	Treatment of actinic keratoses: Apply 0.015% gel to the affected area (face and scalp) once daily for 3 consecutive days. Apply 0.05% gel to the affected area (trunk and extremities) once daily for 3 consecutive days.	The mechanism of action by which ingenol mebutate induces cell death in in treating AK lesions is unknown.

ND Medicaid Agents used to treat Actinic Keratosis Utilization			
05/31/11 - 05/30/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
ALDARA 5% CREAM	6	$886.62	$147.77
FLUOROURACIL 5% CREAM (EFUDEX)	2	$489.30	$244.65
IMIQUIMOD 5% CREAM PACKET	137	$31,214.58	$227.84
102 recipients	**145**	**$32,590.50**	

References

1. PL Detail-Document, Actinic Keratosis Treatments. Pharmacist's Letter/Prescriber's Letter. March 2012.
2. Stockfleth E, et al. Guidelines for the management of actinic keratoses-update 2011. http://www.euroderm.org. (accessed May 30, 2012).
3. Solaraze® [prescribing information]. Melville, NY: PharmaDerm; April 2010.
4. Carac® [prescribing information]. Bridgewater, NJ: Dermik Laboratories; August 2009.
5. Efudex® [prescribing information]. Costa Mesa, CA: Valeant; November 2005.
6. Fluoroplex® [prescribing information]. Irvine, CA: Allergan, Inc. November 2004.
7. Zyclara® [prescribing information]. Scottsdale, AZ: Medicis; February 2012.
8. Picato® [prescribing information]. Parsippany, NY: LEO Pharma Inc.; January 2012.

North Dakota Medicaid
DUR Board Meeting
Moxeza® Review

I. Overview

Moxeza solution is a topical fluoroquinolone anti-infective indicated for the treatment of bacterial conjunctivitis caused by the susceptible strains of the following organisms: Aerococcus viridans*, Corynebacterium macginleyi*, Enterococcus faecalis*, Micrococcus luteus*, Staphylococcus arlettae*, Staphylococcus aureus, Staphylococcus capitis, Staphylococcus epidermidis, Staphylococcus haemolyticus, Staphylococcus hominis, Staphylococcus saprophyticus*, Staphylococcus warneri*, Streptococcus mitis*, Streptococcus pneumoniae, Streptococcus parasanguinis*, Escherichia coli*, Haemophilus influenzae, Klebsiella pneumoniae*, Propionibacterium acnes, Chlamydia trachomatis*.
**Efficacy for this organism was studied in fewer than 10 infections.*

II. Dosage and Administration

Instill 1 drop in the affected eye(s) two times daily for seven days.

III. Warnings and Precautions

- Topical ophthalmic use only.
- Hypersensitivity and anaphylaxis have been reported with systemic use.
- Prolonged use may result in overgrowth of non-susceptible organisms, including fungi.
- Patients should not wear contact lenses if they have signs or symptoms of bacterial conjunctivitis.

IV. Adverse Reactions

The most common adverse reactions reported in 1-2% of patients were eye irritation, pyrexia, and conjunctivitis.

V. Utilization

Ophthalmic Fluoroquinolone Utilization			
05/31/11 - 05/30/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
CIPROFLOXACIN 0.3% EYE DROP	478	$13,777.13	$28.82
LEVOFLOXACIN 0.5% EYE DROPS	3	$273.15	$91.05
MOXEZA 0.5% EYE DROPS	54	$4,578.23	$84.78
VIGAMOX 0.5% EYE DROPS	834	$69,281.91	$83.07
ZYMAR 0.3% EYE DROPS	3	$210.80	$70.27
ZYMAXID 0.5% EYE DROPS	12	$1,034.81	$86.23
1,256 recipients	**1384**	**$89,156.03**	

References

1. Moxeza® [prescribing information]. Fort Worth, TX. Alcon Laboratories, Inc.; 2010.

North Dakota Medicaid
DUR Board Meeting
Lidoderm® Review

I. Overview

Lidocaine is an amide-type local anesthetic agent and is suggested to stabilize neuronal membranes by inhibiting the ionic fluxes required for the initiation and conduction of impulses. The penetration of lidocaine into intact skin after application is sufficient to produce an analgesic effect, but less than the amount necessary to produce a complete sensory block.

II. Indication

Lidoderm is indicated for relief of pain associated with post-herpetic neuralgia. It should be applied only to intact skin.

III. Warnings

- Even a used Lidoderm patch contains a large amount of lidocaine (at least 665mg). The potential exists for a small child or pet to suffer serious adverse effects from chewing or ingesting a new or used patch. It is important for patients to store and dispose of Lidoderm out of the reach of children, pets, and others.

- Excessive dosing by applying Lidoderm to larger areas or for longer than the recommended wearing time should result in increased absorption of lidocaine and high blood concentrations, leading to serious adverse effects. Lidocaine toxicity could be expected at lidocaine blood concentrations above 5 ug/mL. The blood concentration of lidocaine is determined by the rate of systemic absorption and elimination. Longer duration of application, application of more than the recommended number of patches, smaller patients, or impaired elimination may all contribute to increasing the blood concentration of lidocaine.

IV. Precautions

- Patients with severe hepatic disease are at greater risk of developing toxic blood concentrations of lidocaine because of their inability to metabolize lidocaine normally.

- Lidoderm should be used with caution in patients with a history of drug sensitivities, especially if the etiologic agent is uncertain.

- Application to broken or inflamed skin, although not tested, may result in higher blood concentrations of lidocaine from increased absorption. Lidoderm is only recommended for use on intact skin.

- Placement of external heat sources, such as heating pads or electric blankets, over Lidoderm patches is not recommended as this has not been evaluated and may increase plasma lidocaine levels.

- The contact of Lidoderm with eyes, although not studied, should be avoided based on the findings of severe eye irritation with the use of similar products in animals. If eye contact occurs, immediately wash out the eye with water or saline and protect the eye until sensation returns.

V. Drug Interactions

- Lidoderm should be used with caution in patients receiving Class I antiarrhythmic drugs (such as tocainide and mexiletine) since the toxic effects are additive and potentially synergistic.

- When Lidoderm is used concomitantly with other products containing local anesthetic agents, the amount absorbed from all formulations must be considered.

VI. Adverse Reactions

- During or immediately after treatment with Lidoderm, the skin at the site of application may develop blisters, bruising, burning sensation, depigmentation, dermatitis, discoloration, edema, erythema, exfoliation, irritation, papules, petechiae, pruritus, vesicles, or may be the locus of abnormal sensation. These reactions are generally mild and transient, resolving spontaneously within a few minutes to hours.

- Allergic and anaphylactoid reactions associated with lidocaine, although rare, can occur. They are characterized by angioedema, bronchospasm, dermatitis, dyspnea, hypersensitivity, laryngospasm, pruritus, shock, and urticaria.

- Systemic adverse reactions following appropriate use of Lidoderm are unlikely, due to the small dose absorbed.

VII. Dosage and Administration

- Apply Lidoderm to intact skin to cover the most painful area. Apply up to three patches, only once for up to 12 hours within a 24-hour period. Patches may be cut into smaller sizes with scissors prior to removal of the release liner. Clothing may be worn over the area of application. Smaller areas of treatment are recommended in a debilitated patient or a patient with impaired elimination.

VIII. Utilization

Lidoderm Utilization 05/31/11 – 05/30/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
Lidoderm (200 recip)	483	$102,858.89	$212.95 (~$7/patch)

References

1. Lidoderm® [prescribing information]. Chadds Ford, PA. Endo Pharmaceuticals., Inc.; March 2010.

North Dakota Medicaid
DUR Board
Suboxone

ND Medicaid Suboxone Utilization		
05/31/11 - 05/30/12		
Label Name	**Rx Num**	**Total Reimb Amt**
SUBOXONE 8 MG-2 MG SL FILM	4	$604.62
SUBOXONE 2 MG-0.5 MG TABLET SL	16	$2,772.70
SUBOXONE 8 MG-2 MG TABLET SL	601	$174,862.06
66 recipients	**621**	**$178,239.38**

50 eligible Suboxone Recipients Profile Review

Recipients	Dates of Suboxone Use	Notes
1	May 2009 - July 2011	17 narcs since 7/11
2	-	no drug profile since 12/09
3	October 2011 - present	Methadone prior
4	July 2009 - present	Clonazepam/Dextroamphetamine
5	Mar 2012 - May 2012 and Aug 2011 - Jan 2011	Methadone prior
6	Apr 2012 - May 2012 and Mar 2011 - July 2011	Methadone Sep/Oct 2011
7	April 2012 - May 2012 and May 2009 - May 2012	-
8	May 2011 - July 2011 and May 2009 - Oct 2009	Narcotics May 2011 - present
9	Oct 2011 - May 2012	-
10	May 2010 - July 2010 and May 2011	Narcotics all other months
11	Sep 2010 - present	-
12	Mar 2012 - May 2012	Methadone July 2010
13	Mar 2009 - Sep 2009	Narcotics all other months
14	2009 - present	-
15	Dec 2009 - Aug 2010	Methadone prior, Clonazepam after
16	May 2009 - October 2011	-
17	May 2010 - June 2011	No drug profile since 6/11
18	May 2009 - present	Clonazepam/Amphetamine
19	sporadic Nov 2010 - Jan 2012	-
20	April 2011	No profile since
21	Aug 2010 - Sept 2011	Methadone 2 months after then narcs
22	Dec 2011 - Mar 2012	-
23	Jan 2011 - Feb 2011	Narcotics after
24	Apr 2012 - May 2012	-
25	June 2009 - present	-
26	Oct 2010 - Dec 2010	Tramadol after
27	Dec 2011 - present	-
28	Jan 2010 - Jan 2011	no profile since
29	Sep 2011 - present	-
30	Apr 2010 - present	-
31	sporadic 2010	Stimulants

Recipients	Dates of Suboxone Use	Notes
32	May 2009 - Aug 2010	Narcotics after
33	Apr 2010 - present	-
34	June 2010 - present	-
35	July 2011 - present	Methadone prior
36	June 2010 - present	-
37	Feb 2011 - present	-
38	Nov 2011 - present	-
39	May 2009 - present	-
40	Jan 2012-present	Buprenorphine prior
41	April 2011 - present	-
42	Oct 2009 - Nov 2009	-
43	Apr 2011 - present	-
44	Feb 2012 - present	Buprenorphine prior
45	July 2009 - Oct 2009	Narcotics since
46	May 2009 - present	-
47	May 2009 - present	-
48	Sep 2011	-
49	Aug 2009 - May2010	Narcotics since
50	Aug 2008 - Sep 2008	Methadone after

North Dakota Medicaid
DUR Board
Duplicate Narcotic Therapy (H3A)

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
15496	1	BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15585		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15650		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
16297		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
16304		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15357	2	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
18843		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
41412		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
84066		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
13032	3	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
16214		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
10656	4	MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13306		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13688		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
14590		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
1679891907		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
16833		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
15585	5	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
1710052626		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
17848		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
41105		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
10757	6	FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
13306		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
15441		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
16061		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
10980	7	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
12215		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
14526		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
18853		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
19584		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
11834	8	ENDOCET , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
13959		ENDOCET , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
10090	9	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
11179		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
12823		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
14991		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
15326		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
16112		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
16194		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
19846		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
10852	10	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
11828		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12034		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19869		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
17186	11	ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
18063		ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19827		ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
11085	12	HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
16432		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
41318		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
14327	13	DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
15270		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
16437		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
1740254739		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
84049		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
10431	14	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19887		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19983		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
84028		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
18865	15	BUTORPHANOL TARTRATE , FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
10861	16	HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
12034		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
13149		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
13939		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
1740254739		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
19869		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
10756	17	FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
11094		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1134433857		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL ,

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
		OXYCODONE-ACETAMINOPHEN
13123		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1326278912		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
14269		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
15333		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1699087916		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
18084		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
12928	18	FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL
16326	19	HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
16475		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
18468		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
10513	20	HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
13415	21	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
13855		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
15032		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
18911		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
19900		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
12939	21	ENDOCET , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
18865		ENDOCET , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
15343	22	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , TRAMADOL HCL
11611	23	HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
14804		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
16162		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
1740254739		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
1326278912	24	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1669624813		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1710117312		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1942514666		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
10321	25	FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
10838		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
11329		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
12941		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
18084		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
1891888582		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
84086		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
10838	26	ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12071		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13615		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
18911		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19842		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
1740254739	27	MORPHINE SULFATE , MORPHINE SULFATE ER , OPANA ER
19869		MORPHINE SULFATE , MORPHINE SULFATE ER , OPANA ER
12622	28	ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19552		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19591		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19593		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
11179	29	HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
16112		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
19700		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
13929	30	OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12928	31	FENTANYL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
16162	32	MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
15585	33	MORPHINE SULFATE ER , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
17848		MORPHINE SULFATE ER , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
10195	34	FENTANYL , HYDROCODONE-ACETAMINOPHEN , TRAMADOL HCL
13936		FENTANYL , HYDROCODONE-ACETAMINOPHEN , TRAMADOL HCL
14720	35	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
15441		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
16061		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
		ACETAMINOPHEN
16833		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
19813		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
16458	36	OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL , ULTRAM ER
1083910426	37	KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
1740254739		KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
19869		KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
15457	38	MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
19732		MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
84021		MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
12034	39	MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
1740254739		MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
19869		MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
11894	40	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
12079		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
16431		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
11179	41	HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , MORPHINE SULFATE ER
19700		HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , MORPHINE SULFATE ER
15585	42	FENTANYL , OXYCODONE HCL , TRAMADOL HCL
17848		FENTANYL , OXYCODONE HCL , TRAMADOL HCL
16458	43	HYDROMORPHONE HCL , MORPHINE SULFATE , MORPHINE SULFATE ER
10611	44	MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
10854		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
12034		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
1740254739		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
18780		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
19869		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
1740254739	45	FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
19869		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
13302	46	FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
13537		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
15661		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
11179	47	FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL
1306995865		FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL
11277	48	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
14165		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL
14852		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL
14310	49	FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
1740254739		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
17684		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
18780		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
19971		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER

North Dakota Medicaid
DUR Board
Oxycontin TID

Oxycontin tablets are a controlled-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time. Oxycontin is not intended for use on an as needed basis. The controlled-release nature of the formulation allows Oxycontin to be effectively administered every 12 hours.

This report includes all strengths of Oxycontin in which patients were given 69 tablets or more per month, indicating three times a day dosing (TID). From 05/31/11 through 05/30/12 there were 190 scripts of Oxycontin filled with TID dosing. There were 18 recipients **(14% of total)** and 23 prescribers **(16% of total)**. Oxycontin prescribed with TID dosing makes up approximately **47%** of the Oxycontin spend.

Oxycontin TID dosing 05/31/11 – 05/30/12			
Drug Name	**Number of Prescriptions**	**Total Reimb Amount**	**Unique Number of Recipients**
Oxycontin (all)	791	$286,997.57	125
Oxycontin TID	190	$134,734.68	18

Summary by Age of the 18 recipients taking Oxycontin TID:

31-40	2
41-50	5
51-60	10
60 and above	1

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
1	6/7/2011	OXYCONTIN 20 MG TABLET	90	30
	6/7/2011	OXYCONTIN 40 MG TABLET	90	30
	7/2/2011	OXYCONTIN 20 MG TABLET	90	30
	7/2/2011	OXYCONTIN 40 MG TABLET	90	30
	7/29/2011	OXYCONTIN 20 MG TABLET	90	30
	7/29/2011	OXYCONTIN 40 MG TABLET	90	30
	8/24/2011	OXYCONTIN 20 MG TABLET	90	30
	8/24/2011	OXYCONTIN 40 MG TABLET	90	30
	9/21/2011	OXYCONTIN 20 MG TABLET	90	30
	9/21/2011	OXYCONTIN 40 MG TABLET	90	30
	10/18/2011	OXYCONTIN 20 MG TABLET	90	30
	10/18/2011	OXYCONTIN 40 MG TABLET	90	30
	11/14/2011	OXYCONTIN 20 MG TABLET	84	28
	12/12/2011	OXYCONTIN 20 MG TABLET	84	28

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
1 (cont'd)	12/13/2011	OXYCONTIN 40 MG TABLET	84	28
	1/13/2012	OXYCONTIN 20 MG TABLET	84	28
	1/20/2012	OXYCONTIN 40 MG TABLET	84	28
	2/8/2012	OXYCONTIN 20 MG TABLET	84	28
	2/14/2012	OXYCONTIN 40 MG TABLET	84	28
	3/13/2012	OXYCONTIN 20 MG TABLET	84	28
	3/13/2012	OXYCONTIN 40 MG TABLET	84	28
	4/11/2012	OXYCONTIN 20 MG TABLET	84	28
	4/11/2012	OXYCONTIN 40 MG TABLET	84	28
	5/8/2012	OXYCONTIN 20 MG TABLET	84	28
	5/8/2012	OXYCONTIN 40 MG TABLET	84	28
2	6/16/2011	OXYCONTIN 20 MG TABLET	84	28
	6/20/2011	OXYCONTIN 40 MG TABLET	84	28
	7/15/2011	OXYCONTIN 20 MG TABLET	84	28
	7/19/2011	OXYCONTIN 40 MG TABLET	84	28
	8/15/2011	OXYCONTIN 20 MG TABLET	84	28
	8/19/2011	OXYCONTIN 40 MG TABLET	84	28
	9/15/2011	OXYCONTIN 20 MG TABLET	84	28
	9/19/2011	OXYCONTIN 40 MG TABLET	84	28
	10/15/2011	OXYCONTIN 20 MG TABLET	84	28
	10/18/2011	OXYCONTIN 40 MG TABLET	84	28
	11/15/2011	OXYCONTIN 20 MG TABLET	90	22
	11/18/2011	OXYCONTIN 40 MG TABLET	90	30
	12/16/2011	OXYCONTIN 40 MG TABLET	90	30
	12/19/2011	OXYCONTIN 20 MG TABLET	90	30
	1/16/2012	OXYCONTIN 40 MG TABLET	90	30
	1/18/2012	OXYCONTIN 20 MG TABLET	90	30
	2/15/2012	OXYCONTIN 40 MG TABLET	90	30
	2/16/2012	OXYCONTIN 20 MG TABLET	90	30
	3/15/2012	OXYCONTIN 40 MG TABLET	90	30
	3/16/2012	OXYCONTIN 20 MG TABLET	90	30
	4/13/2012	OXYCONTIN 40 MG TABLET	90	30
	4/14/2012	OXYCONTIN 20 MG TABLET	90	30
	5/12/2012	OXYCONTIN 40 MG TABLET	120	30
	5/14/2012	OXYCONTIN 20 MG TABLET	120	30
3	11/18/2011	OXYCONTIN 20 MG TABLET	90	30
	11/18/2011	OXYCONTIN 80 MG TABLET	90	30
	12/16/2011	OXYCONTIN 20 MG TABLET	90	30
	12/16/2011	OXYCONTIN 80 MG TABLET	120	30
	1/13/2012	OXYCONTIN 20 MG TABLET	120	30
	1/13/2012	OXYCONTIN 80 MG TABLET	120	30
	2/10/2012	OXYCONTIN 20 MG TABLET	120	30
	2/10/2012	OXYCONTIN 80 MG TABLET	120	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
3 (cont'd)	3/8/2012	OXYCONTIN 20 MG TABLET	120	30
	3/8/2012	OXYCONTIN 80 MG TABLET	120	30
	4/6/2012	OXYCONTIN 20 MG TABLET	120	30
	4/6/2012	OXYCONTIN 80 MG TABLET	120	30
	5/6/2012	OXYCONTIN 20 MG TABLET	120	30
	5/6/2012	OXYCONTIN 80 MG TABLET	120	30
4	11/8/2011	OXYCONTIN 20 MG TABLET	120	30
	12/7/2011	OXYCONTIN 40 MG TABLET	90	30
5	6/9/2011	OXYCONTIN 20 MG TABLET	90	30
	6/9/2011	OXYCONTIN 40 MG TABLET	90	30
	7/8/2011	OXYCONTIN 20 MG TABLET	90	30
	7/8/2011	OXYCONTIN 40 MG TABLET	90	30
	8/12/2011	OXYCONTIN 20 MG TABLET	90	30
	8/12/2011	OXYCONTIN 40 MG TABLET	90	30
	9/21/2011	OXYCONTIN 20 MG TABLET	90	30
	9/21/2011	OXYCONTIN 40 MG TABLET	90	30
	10/27/2011	OXYCONTIN 20 MG TABLET	90	30
	10/27/2011	OXYCONTIN 40 MG TABLET	90	30
	12/1/2011	OXYCONTIN 20 MG TABLET	90	30
	12/1/2011	OXYCONTIN 40 MG TABLET	90	30
	1/6/2012	OXYCONTIN 20 MG TABLET	90	30
	1/6/2012	OXYCONTIN 40 MG TABLET	90	30
	2/10/2012	OXYCONTIN 20 MG TABLET	90	30
	2/10/2012	OXYCONTIN 40 MG TABLET	90	30
	3/7/2012	OXYCONTIN 20 MG TABLET	90	30
	3/7/2012	OXYCONTIN 40 MG TABLET	90	30
	4/20/2012	OXYCONTIN 20 MG TABLET	90	30
	4/20/2012	OXYCONTIN 40 MG TABLET	90	30
	5/24/2012	OXYCONTIN 20 MG TABLET	90	30
	5/24/2012	OXYCONTIN 40 MG TABLET	90	30
6	4/24/2012	OXYCONTIN 80 MG TABLET	90	30
	5/24/2012	OXYCONTIN 80 MG TABLET	90	30
7	6/9/2011	OXYCONTIN 80 MG TABLET	90	30
	7/12/2011	OXYCONTIN 80 MG TABLET	90	30
	8/10/2011	OXYCONTIN 80 MG TABLET	90	30
	9/10/2011	OXYCONTIN 80 MG TABLET	90	30
	10/8/2011	OXYCONTIN 80 MG TABLET	90	30
	11/11/2011	OXYCONTIN 80 MG TABLET	90	30
	12/10/2011	OXYCONTIN 80 MG TABLET	90	30
	1/9/2012	OXYCONTIN 80 MG TABLET	90	30
	2/9/2012	OXYCONTIN 80 MG TABLET	90	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
7 (cont'd)	3/7/2012	OXYCONTIN 80 MG TABLET	90	30
	4/18/2012	OXYCONTIN 80 MG TABLET	90	30
	5/17/2012	OXYCONTIN 80 MG TABLET	90	30
8	6/17/2011	OXYCONTIN 40 MG TABLET	90	30
	7/22/2011	OXYCONTIN 40 MG TABLET	90	30
	8/22/2011	OXYCONTIN 40 MG TABLET	90	30
	9/22/2011	OXYCONTIN 40 MG TABLET	90	30
	10/22/2011	OXYCONTIN 40 MG TABLET	90	30
	11/28/2011	OXYCONTIN 40 MG TABLET	90	30
	12/30/2011	OXYCONTIN 40 MG TABLET	90	30
	2/2/2012	OXYCONTIN 40 MG TABLET	90	30
	3/5/2012	OXYCONTIN 40 MG TABLET	90	30
	4/2/2012	OXYCONTIN 40 MG TABLET	90	30
	5/1/2012	OXYCONTIN 40 MG TABLET	90	30
9	6/13/2011	OXYCONTIN 80 MG TABLET	90	30
	7/14/2011	OXYCONTIN 80 MG TABLET	90	30
	8/11/2011	OXYCONTIN 80 MG TABLET	90	30
	9/15/2011	OXYCONTIN 80 MG TABLET	90	30
	10/21/2011	OXYCONTIN 80 MG TABLET	90	30
	11/21/2011	OXYCONTIN 80 MG TABLET	90	30
	12/23/2011	OXYCONTIN 80 MG TABLET	90	30
	1/20/2012	OXYCONTIN 80 MG TABLET	90	30
	2/18/2012	OXYCONTIN 80 MG TABLET	90	30
	3/19/2012	OXYCONTIN 80 MG TABLET	90	30
	4/17/2012	OXYCONTIN 80 MG TABLET	90	30
	5/24/2012	OXYCONTIN 80 MG TABLET	90	30
10	6/22/2011	OXYCONTIN 20 MG TABLET	90	30
	7/18/2011	OXYCONTIN 20 MG TABLET	90	30
	8/22/2011	OXYCONTIN 20 MG TABLET	90	30
	9/20/2011	OXYCONTIN 20 MG TABLET	90	30
11	6/28/2011	OXYCONTIN 40 MG TABLET	90	30
	7/27/2011	OXYCONTIN 40 MG TABLET	84	28
	8/23/2011	OXYCONTIN 40 MG TABLET	84	28
	9/20/2011	OXYCONTIN 40 MG TABLET	84	28
	10/15/2011	OXYCONTIN 40 MG TABLET	84	28
	11/14/2011	OXYCONTIN 40 MG TABLET	84	28
	12/15/2011	OXYCONTIN 40 MG TABLET	84	28
12	6/10/2011	OXYCONTIN 40 MG TABLET	84	28
	7/6/2011	OXYCONTIN 40 MG TABLET	84	28
	8/3/2011	OXYCONTIN 40 MG TABLET	84	28

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
12 (cont'd)	8/29/2011	OXYCONTIN 40 MG TABLET	84	28
	10/3/2011	OXYCONTIN 40 MG TABLET	84	28
13	5/31/2011	OXYCONTIN 40 MG TABLET	84	28
	6/30/2011	OXYCONTIN 40 MG TABLET	90	30
	8/25/2011	OXYCONTIN 40 MG TABLET	90	30
	9/23/2011	OXYCONTIN 40 MG TABLET	90	30
	10/18/2011	OXYCONTIN 40 MG TABLET	90	30
	11/12/2011	OXYCONTIN 40 MG TABLET	90	30
	12/8/2011	OXYCONTIN 40 MG TABLET	90	30
	1/27/2012	OXYCONTIN 40 MG TABLET	90	30
	2/27/2012	OXYCONTIN 40 MG TABLET	90	30
14	6/24/2011	OXYCONTIN 10 MG TABLET	90	30
	7/25/2011	OXYCONTIN 10 MG TABLET	90	30
	8/24/2011	OXYCONTIN 10 MG TABLET	90	30
	9/23/2011	OXYCONTIN 10 MG TABLET	90	30
	10/21/2011	OXYCONTIN 10 MG TABLET	90	30
	11/18/2011	OXYCONTIN 10 MG TABLET	90	30
	12/16/2011	OXYCONTIN 10 MG TABLET	90	30
	1/13/2012	OXYCONTIN 10 MG TABLET	90	30
	2/10/2012	OXYCONTIN 10 MG TABLET	90	30
	3/12/2012	OXYCONTIN 10 MG TABLET	90	30
	4/9/2012	OXYCONTIN 10 MG TABLET	90	30
15	8/31/2011	OXYCONTIN 80 MG TABLET	90	30
	9/29/2011	OXYCONTIN 80 MG TABLET	90	30
	3/29/2012	OXYCONTIN 80 MG TABLET	90	30
	4/28/2012	OXYCONTIN 80 MG TABLET	90	30
	5/26/2012	OXYCONTIN 80 MG TABLET	90	30
16	6/8/2011	OXYCONTIN 40 MG TABLET	90	30
	7/13/2011	OXYCONTIN 40 MG TABLET	90	30
	8/10/2011	OXYCONTIN 40 MG TABLET	90	30
	9/6/2011	OXYCONTIN 40 MG TABLET	90	30
	10/3/2011	OXYCONTIN 40 MG TABLET	90	30
	10/31/2011	OXYCONTIN 40 MG TABLET	90	30
	11/23/2011	OXYCONTIN 40 MG TABLET	90	30
	1/18/2012	OXYCONTIN 20 MG TABLET	90	30
	2/15/2012	OXYCONTIN 20 MG TABLET	90	30
	3/13/2012	OXYCONTIN 20 MG TABLET	90	30
	4/11/2012	OXYCONTIN 20 MG TABLET	90	30
	5/9/2012	OXYCONTIN 20 MG TABLET	90	30
17	7/11/2011	OXYCONTIN 80 MG TABLET	90	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
17 (cont'd)	8/6/2011	OXYCONTIN 80 MG TABLET	90	30
	9/2/2011	OXYCONTIN 80 MG TABLET	84	28
	9/29/2011	OXYCONTIN 80 MG TABLET	84	28
	10/31/2011	OXYCONTIN 80 MG TABLET	90	30
	11/28/2011	OXYCONTIN 80 MG TABLET	90	30
	12/28/2011	OXYCONTIN 80 MG TABLET	90	30
	1/24/2012	OXYCONTIN 80 MG TABLET	90	30
	2/22/2012	OXYCONTIN 80 MG TABLET	90	30
	3/22/2012	OXYCONTIN 80 MG TABLET	90	30
	4/18/2012	OXYCONTIN 80 MG TABLET	90	30
	5/16/2012	OXYCONTIN 80 MG TABLET	93	31
18	5/18/2012	OXYCONTIN 10 MG TABLET	90	30

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
3RD QUARTER 2012

Criteria Recommendations ***Approved Rejected***

1. Ranolazine / Potent CYP3A4 Inducers _____ _____

Alert Message: Ranexa (ranolazine) is contraindicated in patients receiving CYP3A4 inducers. Ranolazine is a CYP3A4 substrate and concurrent use with a CYP3A4 inducer can result in decreased plasma concentrations of ranolazine and loss of therapeutic effect.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Ranolazine	Rifampin	
	Barbiturates	
	Phenytoin	
	Carbamazepine	
	Oxcarbazepine	
	Rifabutin	
	Rifapentine	
	Bosentan	
	Pioglitazone	
	Modafinil	
	Armodafinil	
	Prednisone	
	Nevirapine	
	Efavirenz	
	Etravirine	

References:
Ranexa Prescribing Information, Dec. 2011, Gilead Sciences, Inc.
Facts & Comparisons, 2012 Updates.

2. Aliskiren-All / ACEIs & ARBs / Renal Impairment _____ _____

Alert Message: Avoid concomitant use of aliskiren-containing products with ARBs or ACEIs in patients with renal impairment where GFR is < 60 mL/min. Patients receiving this combination of medications may be at particular risk of developing acute renal failure.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Aliskiren-All	ACE Inhibitors	Renal Impairment
	ARBs	

References:
MedWatch The FDA Safety Information and Adverse Event Reporting Program. Aliskiren-containing Medications: Drug Safety Communication - New Warning and Contraindication. [Posted 04/20/2012].
Tekturna Prescribing Information, March 2012, Novartis Pharmaceuticals Corp.
Amturnide Prescribing Information, March 2012, Novartis Pharmaceuticals, Corp.
Tekturna HCT Prescribing Information, March 2012, Novartis Pharmaceutical Corp.
Tekturna Prescribing Information, March 2012, Novartis Pharmaceutical Corp.

3. Methotrexate / Proton Pump Inhibitors _____ _____

Alert Message: The concurrent administration of a proton pump inhibitor (PPI) and methotrexate (primarily at high dose) may elevate and prolong serum levels of methotrexate and/or its metabolite, possibly leading to methotrexate toxicities. A temporary withdrawal of the PPI (several days before and after methotrexate administration) may be considered in some patients.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Methotrexate	Omeprazole	
	Lansoprazole	
	Pantoprazole	
	Rabeprazole	
	Esomeprazole	
	Dexlansoprazole	

References:
Bezabeh S, Mackey AC, Kluetz P et al., Accumulating Evidence for a Drug-Drug Interaction between Methotrexate and Proton Pump Inhibitors. The Oncologist. April 1, 2012;17:550-554.
Methotrexate Prescribing Information, October 2011, Hospira, Inc.
Clinical Pharmacology, 2012, Elsevier/Gold Standard.

4. Abiraterone / Therapeutic Appropriateness _____ _____

Alert Message: A review of the patient's recent drug history does not indicate the concurrent use of Zytiga (abiraterone) with prednisone. In order to reduce the risk of adrenocortical insufficiency (AI), abiraterone should be used in combination with low-dose prednisone.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Abiraterone		Prednisone

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc
Facts & Comparisons, 2012 Updates.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Attard G, Reid AH, Auchus RJ, et al. Clinical and biochemical consequences of CYP17A1 inhibition with abiraterone given with and without exogenous glucocorticoids in castrate men with advanced prostate cancer. J Clin Endocrinol Metab. 2012 Feb;97(2):507-16.

5. Abiraterone / Therapeutic Appropriateness _____ _____

Alert Message: Zytiga (abiraterone) may cause elevated transaminases, and it is recommended that patients with moderate hepatic impairment monitor ALT, AST and bilirubin prior to the start of treatment, every week for the first month, every two weeks for the next two months, and monthly thereafter. Abiraterone should be discontinued in patients with ALT or AST greater than 5 times upper limit of normal (ULN) or total bilirubin greater than 3 times ULN.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C (Include)
Abiraterone		Chronic Liver Disease
		Cirrhosis

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

6. Abiraterone / Overuse _____ _____

Alert Message: Zytiga (abiraterone) may be over-utilized. The manufacturer's maximum recommended dose is 1000mg every day in combination with prednisone 5mg twice daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Abiraterone		Chronic Liver Disease
		Cirrhosis

Max Dose: 1000mg/day

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

7. Abiraterone / Moderate & Severe Hepatic Impairment _____ _____

Alert Message: Zytiga (abiraterone) may be over-utilized. Patients with moderately impaired hepatic function (Child-Pugh Class B) should be started at a dose of 250mg/day. The manufacturer recommends that abiraterone be avoided in patients with severe hepatic impairment (Child-Pugh Class C).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C (Include)
Abiraterone		Chronic Liver Disease
		Cirrhosis

Max Dose: 250mg/day

References
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

8. Abiraterone / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Zytiga (abiraterone) is FDA pregnancy category X and is contraindicated during pregnancy and in women of childbearing potential due to risk of potential adverse effects to the fetus.

Conflict Code: MC – Drug/Diagnosis Precaution/Warning/Contraindication
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Abiraterone	Pregnancy ICD-9s	Delivery
		Miscarriage
		Abortion

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

9. Abiraterone / History of Cardiovascular Disease _____ _____

Alert Message: Zytiga (abiraterone) should be used with caution in patients with a history of cardiovascular disease (e.g., recent myocardial infarction or ventricular arrhythmia). Abiraterone may cause hypertension, hypokalemia and fluid retention due to increased mineralocorticoid levels from CYP17 inhibition.

Conflict Code: MC – Drug/Diagnosis Precaution/Warning/Contraindication
Drugs/Diseases

Util A	Util B	Util C
Abiraterone	Myocardial Infarction	
	Ventricular Arrhythmia	

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

10. Abiraterone / History of Heart Failure _____ _____

Alert Message: The safety of Zytiga (abiraterone) in patients with left ventricular ejection fraction < 50% or NYHA Class III or IV heart failure has not been established. If treatment with abiraterone is necessary, monitor patients for hypertension, hypokalemia and fluid retention at least once a month.

Conflict Code: MC – Drug/Diagnosis Precaution/Warning/Contraindication
Drugs/Diseases

Util A	Util B	Util C
Abiraterone	Heart Failure	

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

11. Abiraterone / Drugs that Induce or Inhibit CYP3A4 _____ _____

Alert Message: Zytiga (abiraterone) is a substrate of CYP3A4. The effects of strong CYP3A4 inhibitors (e.g., ketoconazole, clarithromycin, etc.) or inducers (e.g., phenytoin, carbamazepine, etc.) on the pharmacokinetics of abiraterone have not been evaluated. Use of strong inhibitors and inducers of CYP3A4 should be avoided or used with caution during abiraterone therapy.

Conflict Code: ER – Overutilization
Drugs/Diseases

Util A	Util B			Util C
Abiraterone	Ketoconazole	Itraconazole	Clarithromycin	
	Atazanavir	Nefazodone	Saquinavir	
	Telithromycin	Ritonavir	Indinavir	
	Nelfinavir	Voriconazole	Phenytoin	
	Carbamazepine	Rifampin	Rifabutin	
	Rifapentine	Phenobarbital		

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Flockhart DA. Drug Interactions: Cytochrome P450 Drug Interaction Table. Indiana University School of Medicine. Available at: Http://medicine.iupui.edu/clinpharm/ddos/table.asp. Accessed 04/2012.

12. Abiraterone / Substrates of CYP2D6 _____ _____

Alert Message: Zytiga (abiraterone) is an inhibitor of CYP2D6. Co-administration of abiraterone and substrates of CYP2D6 with a narrow therapeutic index (e.g., thioridazine) should be avoided. If alternative treatments cannot be used, a dose reduction of the concomitant CYP2D6 drug should be considered.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Abiraterone	Thioridazine	

References:

Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Flockhart DA. Drug Interactions: Cytochrome P450 Drug Interaction Table. Indiana University School of Medicine. Available at: Http://medicine.iupui.edu/clinpharm/ddos/table.asp. Accessed 04/2012.