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Bill Owens
Governor

Stephen C. Tool
Executive Director

December 1, 2006

The Honorable Anne McGihon, Chairman
House Health & Human Service Committee
200 East Colfax
Denver, CO 80203

Dear Representative McGihon:

Enclosed please find a legislative report to the House Health & Human Services Committee on the Department of Health Care Policy and Financing's (Department) Pharmacy Utilization Plan FY 06-07.

C.R.S. § 25.5-5-506(3)(b) (2006) requires the Department to provide the Pharmacy Utilization Plan on an annual basis to the General Asembly.

The Pharmacy Utilization Plan describes the drug utilization mechanisms implemented by the Department and the estimated savings generated by those mechanisms.

Questions regarding the Pharmacy Utilization Plan can be addressed to Cathy Traugott, Pharmacy Section Manager. Her telephone number is 303-866-2468 and her email address is Catherine.Traugott@state.co.us.

Sincerely,

Stephen C. Tool
Executive Director

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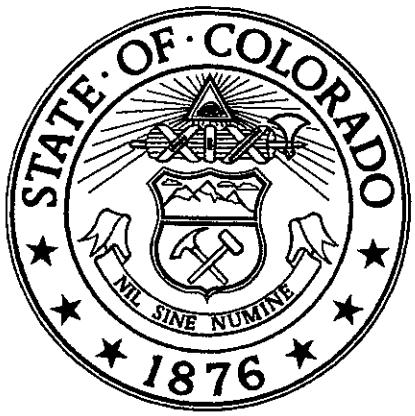
Enclosure



COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REPORT TO THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE, THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE AND THE JOINT BUDGET COMMITTEE

ON

PHARMACY UTILIZATION PLAN FY 06-07

DECEMBER 1, 2006

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INTRODUCTION

The Pharmacy Utilization Plan FY 06-07 is required by C.R.S. § 25.5-5-506(3)(b) (2006) as stated below.

> (b) The state department shall report to the health and human services committees for the house of representatives and the senate, or any successor committees, and the joint budget committee no later than December 1, 2003, and each December 1 thereafter, on plan utilization mechanisms that have been implemented or that will be implemented by the state department, the time frames for implementation, the expected savings associated with each utilization mechanism, and any other information deemed appropriate by the health and human services committees, or any successor committees, or the joint budget committee.

The Department of Health Care Policy and Financing (the Department) has continued to pursue reductions in pharmaceutical expenditures as outlined in SB 03-294 and SB 03-011. The Department has implemented several utilization mechanisms to control costs while allowing access to medications for clients who need them. Such mechanisms include limits and prior authorizations on certain drugs. The Department is also considering other utilization mechanisms to determine if they would result in any reduction in expenditure. The Drug Utilization Review (DUR) Board established by the Department continues to review drug utilization issues and make recommendations to the Department to optimize appropriate prescription drug use. The DUR Board findings are used by the Department to review identified drugs and to achieve expenditure reduction in pharmaceuticals. The Business Research Division of the Leeds School of Business at the University of Colorado (the BRD) also continues to assist the Department with more in-depth analysis of various drug utilization issues. In addition, the Department recently contracted with Comprehensive Neuroscience, Inc. to run the Behavioral Pharmacy Educational (BPE) Program, which identifies misutilization issues regarding mental health drugs and opioids and works with prescribers to change their prescribing habits. Finally, the Department will continue to monitor monthly drug expenditures and provider/client utilization patterns.

Throughout this report, the Department identifies the utilization mechanisms that have been implemented to generate a reduction in expenditures to a specific prescription drug class, rather than attempting to identify a savings to the overall Department's pharmaceutical budget. The amounts reported for a specific drug or drug class do not capture the possible increased utilization of another prescription drug, which may act as a substitute. As an example, the reduction in expenditure from the implementation of prior authorizations on certain drugs in a drug class may have caused clients to shift to another drug in that drug class which is not subject to prior authorization. The reported reductions in expenditures detailed in this report are not offset by the possible increase in expenditure for other drugs. The increase in the utilization for other drugs directly related to the implementation of prior authorizations is not measurable.

PLAN UTILIZATION MECHANISMS PREVIOUSLY IMPLEMENTED

The following calculations contain FY 05-06 measures of the reductions in expenditure for each of the Department's utilization control initiatives. As FY 06-07 is not yet complete, the FY 06-07 figures below are forecasts. In certain categories, the FY 05-06 data below varies from last year's Pharmacy Utilization Plan (FY 05-06 Report) as the data is now complete and also because the calculations were refined and improved.

The Department believes that it is important to note that unmeasurable market factors may affect the reductions in expenditures realized by the implementation of these prior authorizations. This is particularly true for the prior authorizations that were implemented more than a year ago. The Department does not believe it is possible to accurately predict the potential reduction in expenditure after a prior authorization has been implemented for more than a year. There are potential methodologies but many factors make these methodologies unreliable. Those factors include the introduction of new drugs in the drug class, withdrawal of drugs from the market, new drugs in different drug classes that treat the same condition, new studies regarding the effectiveness of the drug, and the implementation of drug coverage changes such as the Medicare Prescription Drug, Improvement and Modernization Act (MMA). Implementation of the MMA particularly makes it difficult to accurately assess the reduction in expenditure for prior authorizations created more than a year ago. Effective January 1, 2006, approximately 15% of the Department's clients no longer received the vast majority of their drugs through the Department. This resulted in a 45.9% decrease in drug expenditures for the Department. As explained in more detail later in this report, the implementation of the MMA caused a significant shift in drug utilization patterns and this makes it difficult to accurately predict any savings, especially for prior authorizations implemented more than a year ago.

The calculated reductions in drug expenditures included in this report were based on claims and claim trends prior to implementation of the prior authorizations or restrictions. Any claims for dual eligibles were excluded from the analysis. Since the Department no longer pays for these drugs for the dual eligibles, any reductions in expenditures for these clients were based on the implementation of the MMA and not the implementation of the prior authorizations or restrictions.

PHASE III: Implemented April 13, 2005

The Department has implemented a number of limits and prior authorizations in phases over the past few fiscal years. Phase I and II have been analyzed in earlier Reports. While the Department believes that the limits and prior authorizations implemented in those Phases are still useful for utilization control, any savings calculations would be difficult given the significant time that has passed and the multiple market factors that could affect those calculations. Thus, no calculations are included in this Report for Phase I and II.

In Phase III, prior authorizations were implemented for the leukotriene receptor antagonists (Accolate and Singulair) and on Bactroban cream and nasal ointment. The details of the prior

authorization process for Phase III and the final prior authorization criteria for these drugs are included in the FY 05-06 Report.

Leukotrienes

Accolate and Singulair were placed on prior authorization for clients who are 21 years old and older. The prior authorization has been more effective on Accolate than Singulair. While the prior authorization has limited use to FDA-approved indications, these drugs are quite popular and use for FDA-approved indications has increased.

FY 05-06 estimated reduction in expenditure within this drug class: $0

Bactroban

Bactroban cream and nasal ointment were also placed on prior authorization. The utilization of this drug has dropped significantly since the implementation of the prior authorization which has resulted in a larger estimated reduction in expenditure than originally projected.

FY 05-06 estimated reduction in expenditure within this drug class: $66,546

Other Changes in FY 05-06

Promethazine Prior Authorization

In addition, the Department put promethazine on prior authorization for clients under the age of two effective September 1, 2005. As explained in greater detail in the FY 05-06 Report, the prior authorization was established primarily to protect the health of our clients under the age of two. The Department realized the reduction in expenditure estimated in the FY 05-06 Report. Based on the reduction of paid claims for this drug for clients under the age of two, in FY 05-06, there was an estimated reduction in expenditure of $15,135 from the implementation of this prior authorization.

Stopped payment of all erectile dysfunction drugs

Last fall, the QI, TMA, and Abstinence Programs Extension and Hurricane Katrina Unemployment Relief Act of 2005 passed, which changed the federal government's policy regarding drugs used to treat erectile dysfunction. Previously, federal policy had mandated that Medicaid programs cover erectile dysfunction drugs. This law stated that Medicaid programs could no longer pay for erectile dysfunction drugs. 42 U.S.C. 1396r-8(d)(2)(K). Pursuant to that law, effective January 1, 2006, the Department stopped payment of drugs used to treat erectile dysfunction. Based on previous usage of these drugs in July through December of 2005, this change in policy resulted in an estimated reduction in expenditure for FY 05-06 of $50,424 and an estimated reduction in expenditure for FY 06-07 of $103,462.

PLAN UTILIZATION MECHANISMS TO BE IMPLEMENTED IN FY 06-07

The Department is continuing to monitor drug utilization and trends to determine if additional drugs should be placed on prior authorization. In addition, the Department will continue to update existing prior authorization criteria based on drug utilization and trends as well as new medical information.

As stated in last year's report, the Department did not believe that it was prudent to invest significant time into additional utilization mechanisms until the impact of the implementation of the MMA was known. Effective January 1, 2006, persons eligible for both Medicare and Medicaid (dual eligibles) began to receive the vast majority of their drugs through the Medicare program. The Department continued to incur a relatively small cost to provide Medicare excluded drugs to these dual eligibles as a Medicaid benefit. However, as predicted, the expenditure amount on pharmaceuticals dropped significantly due to this shift in coverage for the dual eligibles. As reported in the July 10, 2006 letter to the Joint Budget Committee, in the six months prior to the implementation of Part D, the Department's drug expenditures averaged $24,806,691 per month (pre-rebate). The six month average after the implementation of Part D was $13,428,738 (pre-rebate). This is a 45.9% reduction in drug expenditures.

The utilization patterns of drugs also changed significantly due to the change in coverage for the dual eligibles. Many drugs are used primarily or even exclusively by the elderly population and the expenditures on these drugs have dropped significantly. For example, Lipitor (a drug to lower cholesterol) was fifth on the list of drugs ranked by expenditure prior to implementation of Part D. Now Lipitor is no longer in the top ten list. As a result of many drugs decreasing in utilization, other drugs are higher on the Department's expenditure list even though use of the medications may not have increased significantly. For example, Synagis, a drug used to treat respiratory problems in premature babies, is now one of the Department's top ten drugs in terms of costs. (The Department placed Synagis on prior authorization a number of years ago.) Now that the impact of the MMA is better quantified, the Department is moving forward with additional utilization mechanisms.

PHASE IV: Scheduled to be implemented early 2007

The Department recently proposed prior authorizations on a number of drugs based on recent utilization patterns, client health concerns and provider misbilling issues. These drugs are: Provigil, Advair, Tramadol, Zantac liquid, narcotic analgesics containing acetaminophen (Vicodin, Lortab, Lorcet, Norco, Percocet, Darvocet, Wygesic, Fioricet, Tylox, Tylenol with Codeine, Ultracet, Zydone, Panlor, Esgic and all generic equivalents and strengths), ADHD drugs (Ritalin, Concerta, Daytrana, Dexedrine, Adderall, and all generic equivalents and strengths), and injectables (Risperdal Consta, Zyprexa, Geodon, Vivitrol, Didronel, Boniva, Aredia, Miacalcin, Zemplar, Hectorol, Zometa, Pamidronate, Ganite and Xolair). These drugs were considered for prior authorization because of increased utilization, overutilization, potential inappropriate use, and/or avoidance of possible double billing to the Medicaid program. Specifically, Provigil is often used for off-label uses and has safety issues associated with its use. Zantac liquid is an expensive formulation of Zantac and there are less expensive formulations

that can be used by most clients. Tramadol and acetaminophen are toxic when given at high doses and the prior authorization would stop the use of these drugs at those toxic levels. The injectables are often misbilled to the pharmacy section and a prior authorization is useful to prevent misbilling of these drugs. The Department proposed to further restrict the coverage of Dexedrine and Adderall by not covering these drugs for senile depression. This is not an FDA-approved indication for these drugs. The Department proposed to add Ritalin, Concerta, and Daytrana to the prior authorization list so that all drugs used to treat ADHD are subject to the same prior authorization restrictions.

In addition, the Department proposed to lift the prior authorization requirement on drugs used to treat drug addiction such as Methadone, Revia, Revex, Narcan, Depade and Trexan. Historically these drugs were not covered for substance abuse treatment because such treatment was not a Medicaid benefit. However, effective July 1, 2006, the Department now provides a substance abuse treatment program as a benefit and thus the Department believes that these drugs should be covered as a part of that treatment program.

The Department asked for input on the proposals from the Colorado Medical Society, the Denver Medical Society, the Department's DUR Board, and manufacturers of the drugs. In addition, the Department posted the possible prior authorization criteria so that anyone from the public could submit comments. The Department has received a number of comments and recommendations on the list of drugs. The Department is considering all comments and recommendations that were received during this process and will make a final determination on the drugs that will be prior authorized shortly.

The proposed prior authorization criteria are listed below:

Prior Authorization Criteria	
Medication	**Criteria**
Zantac Liquid	For clients 12 to 64 years of age. A PA will be granted for clients with a feeding tube or who have difficulty swallowing. *No PA is required for children under 12 years of age.*
Methadone/Revia/Revex/ Narcan/Depade/Trexan	A PA will no longer be required
Tramadol	A Prior authorization is required for more than 8 tablets per day or 400mg/day
Vicodin/Lortab/Lorcet/ Norco/Percocet/Darvocet/ Wygesic/Fioricet/Tylox/ Tylenol w/ Codeine/ Ultracet/Zydone/Panlor/ Esgic and all generic equivalents and strengths	A Prior authorization is required for dosages over 3800mg/day
Injectables:	Approved only when the medication is administered in a long-

RisperdalConsta/Zyprexa/ Geodon/Vivitrol/Didronel/ Boniva/Aredia/Miacalcin/ Zemplar/Hectorol/Zometa/ Pamidronate/Ganite/Xolair	term care facility or in a client's home for a FDA approved indication
Provigil	Approved for clients 16 years of age and older with excessive sleepiness associated with one of the following conditions: ➢ Narcolepsy ➢ Obstructive Sleep Apnea/Hypopnea Syndrome ➢ Shift Work Sleep Disorder
Ritalin/Concerta/Daytrana	Prior authorization is required for clients 5 years of age and under (3-5 years old) and for clients 18 years of age and older, both must meet the following criteria: ➢ Clients must be 3 years of age or older ➢ Diagnosis of Narcolepsy, ADD or ADHD *Notes:* ➢ *Clients between the ages of 6-17 years old do not require a prior authorization.* ➢ *A PA will not be granted for a diagnosis of obesity control*
Dexedrine and Adderall	*Approvals will no longer be given for senile depression.* The current criteria will remain the same. Prior authorization is required for clients 5 years of age and under (3-5 years old) and for clients 18 years of age and older, both must meet the following criteria: ➢ Clients must be 3 years of age or older ➢ Diagnosis of Narcolepsy, ADD or ADHD *Notes:* ➢ *Clients between the ages of 6-17 years old do not require a prior authorization.* ➢ *A PA will not be granted for a diagnosis of obesity control*
Advair	<u>Clients must meet all of the following criteria for approval:</u> ➢ Diagnosis of Asthma ➢ 4 years of age and older ➢ Treatment failure with inhaled corticosteroids or client was stabilized on Advair at the time the PA was implemented ➢ Prescription filled in the past six months for an inhaled, short-acting beta agonist <u>Additional Criteria for Advair 250/50:</u> Approval will be granted for a diagnosis of Asthma or Chronic Obstructive Pulmonary Disease (COPD) associated with Chronic Bronchitis.

By correcting the overutilization, inappropriate use and misbilling issues associated with these drugs, the Department anticipates a reduction in expenditure associated with these drugs. The FY 06-07 estimated reductions in expenditure for these drugs are as follows:

Zantac Liquid: $49,096
Tramadol: $7,240
Narcotic Analgesics: $2,608
Injectables: $478,310
Provigil: $122,243
ADHD drug class: $14,478
Advair: $228,578[1]

As FY 06-07 is not yet complete, these FY 06-07 figures are forecasts. For these forecasts, the Department assumed the proposed prior authorizations would be implemented on March 1, 2007. Thus the estimated reductions in expenditure are prorated for that portion of FY 06-07. Again, it is important to note that these are only estimates and that many immeasurable market factors may affect the reductions in expenditures actually realized by the Department.

The Department is continuing to monitor drug utilization and trends to determine if additional drugs should be placed on prior authorization. In addition, the Department will continue to update existing prior authorization criteria based on drug utilization and trends as well as new medical information.

OTHER ACTIVITIES

DUR Board Activities

In accordance with Federal law, the DUR Board performs various drug utilization review functions including retrospective drug utilization review and education to providers. The DUR Board also reviews certain policies of the Department and provides recommendations with regard to those policies.

The DUR Board is currently comprised of the following members:

Lucy Williams Loomis, M.D., M.S.P.H.
James R. Kant, R.Ph.
Robert D. McCartney, M.D., F.A.C.P.
Mary Newell, R.Ph.
Robert Lee Page II, Pharm. D.
James Regan, M.D.
Terrie A. Sajbel, Pharm. D.
Edra B. Weiss, M.D., F.A.A.P.
Robert Host (pharmaceutical representative).

[1] These estimated reductions in expenditures were calculated by the BRD.

Kimberly Eggert, R.Ph., attends the Board's meetings as the Department's representative but does not hold a voting position on the Board. Health Information Designs, Inc. (HID), the Department's contractor, continues to provide assistance with the DUR Board. A HID representative, Candace Rieth, R.Ph., attends the DUR Board meetings.

The Board meets on a quarterly basis and holds special meetings when deemed necessary. During FY 05-06, the Board considered a number of issues including the review of certain prior authorization criteria such as the proton pump inhibitor criteria; a recommendation to the Department to add Zantac liquid to the prior authorization criteria; and review of the retrospective drug utilization review criteria that is used to create client profiles and identify any potential misutilization issues (discussed below). The Department has considered all of the recommendations of the DUR Board and in many cases, has implemented the recommendations.

The Board and HID also review client drug profiles to determine if there are any utilization issues that need to be addressed. Educational letters are sent to providers regarding prescribing practices that could be deemed inappropriate. The goal of the program is to inform providers of potential drug utilization problems and change prescribing habits toward better utilization protocols. In FY 05-06, the Board and HID reviewed inappropriate use of non-steroidal anti-inflammatory drugs (NSAIDs), use of sedative/hypnotic drugs in depressed clients, over-utilization of various medications, use of seizure causing agents in epileptic clients, overdosing of drugs containing acetaminophen, over-utilization of narcotics, diabetics with a history of congestive heart disease, therapeutic duplication of antipsychotics, duplicative use of selective serotonin reuptake inhibitors, use of anticonvulsants and antidepressants, duplicate therapy and over-utilization of sedative/hypnotics, sedative/stimulant therapy and skeletal muscle relaxant duplication/over-utilization.

HID provides a quarterly and biennial report of its activities and the activities of the DUR Board. The most recent biennial report was for the first six months of FY 05-06. During that time, HID and the DUR Board looked at inappropriate use of NSAIDs, use of sedative/hypnotic drugs in depressed clients, over-utilization of various medications, use of seizure causing agents in epileptic clients, overdosing of drugs containing acetaminophen and over-utilization of narcotics. There were 1,994 clients identified with potential drug therapy issues. Letters were sent to physicians in 1,620 of those cases. The categories of drug therapy problems and percentage of cases in each category identified were as follows: 22% drug-disease interactions, 40% drug-drug conflict, 31% overutilization, 2% underutilization and 5% clinical appropriateness. There were 782 physicians who responded to the letters (a response rate of 48%). There were a variety of responses from the physicians, including modification or discontinuance of therapy, several who scheduled appointments to discuss the issue with the clients and several who tried to modify therapy but the symptoms recurred. HID determined that the changes to appropriate therapy resulted in a reduction in expenditure of $1,142,875 to the Department during that time. They also estimated that the Department's return on investment was $23.84 for every dollar spent on the contract with HID. Thus, although the primary goal of the DUR program is provider education and appropriate drug therapy, the program did result in a reduction of expenditures to the Department.

Utilization Research by the Business Research Division of the Leeds School of Business at the University of Colorado (the BRD)

The BRD performs a variety of research and analytical projects as directed by the Department to facilitate retrospective review of and reporting on the appropriateness of prescription drug use, provider prescribing habits, and the potential fiscal impact of drug utilization issues such as drug-drug interactions, drug-disease interactions and therapeutic duplication. In FY 05-06, the BRD performed analysis for previously implemented prior authorizations and limits and the impact of those initiatives on the Department's budget. The BRD also provided analysis on billing issues such as the coverage of over-the-counter drugs in nursing homes.

The BRD also produces a "Top 25 Drugs" report, which dissects Colorado Medicaid drug expenditures by gender, age, county, expenditure concentration[2], side-effects, utilization rates, and a cross-tabulation of linked drugs (so-called poly-pharmaceutical medications).

Beginning FY 05-06, the BRD undertook a survey of other states' drug utilization strategies and analyzed the potential effectiveness of those strategies in Colorado. The BRD found that tablet splitting is becoming a popular initiative for other states (ten states currently require some form of tablet splitting) and contributes considerable savings. The BRD has determined those medications that are prime candidates for a tablet-splitting requirement, as well as the expected savings for each candidate under the potential program. The BRD has also evaluated the risks inherent in this type of program. The Department is currently reviewing the proposed program to determine its feasibility in Colorado.

The Department is considering using the BRD to implement a pilot academic detailing program that would enhance communication between the Department and its providers. The goal of academic detailing is to ensure that providers such as pharmacies and physicians are aware of drug utilization issues such as generic prescribing options, the prior authorizations requirements, proper use of override and dispensing codes, and system and policy changes. The Department already posts such information on the Department's website and includes such information in provider bulletins. The BRD would call and meet with providers, particularly those who seem to not understand Department policies, to provide another method of communication with those providers. The BRD would then prepare reports for the Department summarizing the results of the meeting and providing any feedback given by the providers to the Department.

BPE Program

Starting June 1, 2006, the Department engaged in a two-year project with CNS to run the BPE Program. Through this Program, the Department is able to provide information to prescribers about the psychiatric and opioid medication utilization of their patients. The program is entirely funded by a grant from Eli Lilly and thus results in no cost to the Department.

[2] Expenditure concentration is a percentage measure that divides the number of clients by the total expenditures. A high expenditure concentration indicates, for example, that 5% of the clients account for 40% of the total drug cost. This concentration indicator provides a focus for Departmental cost-containing strategies.

The BPE program is designed to help ensure that the Department's clients receive the best care possible through more appropriate utilization of these medications. CNS has extensive experience in evidence-based and consensus-based standards for psychiatric medication prescribing and has administrated several similar projects for a number of other Medicaid programs. Twenty-five other states have also entered into similar agreements with CNS. Missouri, one of the first states, just received the 2006 Bronze Achievement Award from the American Psychiatric Association for success in improving the quality of prescribing practices for psychiatric medications and patient outcomes.

During the span of the BPE Program, educational alerts/letters will be sent to prescribers to inform them if the medication dosing for their patients is in line with FDA guidelines and, for children, research and consensus-based guidelines. The messages are advisory and intended to be supportive. Prescribers are asked to review each case in the context of the guidelines and decide individually what is best for the patient. The program is also designed to notify prescribers about forgotten refills and when a patient obtains the same class of drug from multiple prescribers. If prescribing patterns do not change, follow-up letters are sent to the prescribers. When deemed necessary, peer consultants meet with prescribers to discuss their prescribing habits and current clinical information regarding the drugs.

While the BPE program is intended to be educational, many state Medicaid programs that have been engaged in the BPE program for a longer period of time have documented significant cost savings. According to a press release by the Missouri Department of Mental Health dated October 26, 2006[3], Missouri's program has contributed to at least $7.7 million in Medicaid pharmacy cost savings. In addition, the Utah program shows a significant decrease between expected and actual monthly behavioral pharmacy spending, a decrease in monthly behavioral prescriptions per patient for high-risk patients, and no increase in monthly behavioral pharmacy claims despite an increase in the Medicaid membership. The difference between the expected cost of behavioral health drugs if the CNS program had not been implemented and the actual cost since the program's inception has been a savings of almost ten million dollars quarterly. Even though several state Medicaid programs have had significant savings in pharmacy, hospitalizations and acute care events, a few states have not had the same results. Regardless, based on the data that has been presented by CNS, the Department expects the program to improve the quality of care for the Department's clients and anticipates that the program will likely provide cost savings.

Market Changes

The Department's pharmacy budget decreased significantly due to the implementation of Part D. Despite that change, drug costs continue to rise as new drugs often are very expensive and drug manufacturers are also increasing drug prices of older drugs. The Department continues to monitor market changes to determine possible areas for savings.

[3] http://www.dmh.mo.gov/2006NewsReleases.htm#pharmproject

CONCLUSION

The Department has implemented a number of drug utilization mechanisms to control costs. Throughout this report, the Department identifies the utilization mechanisms that have been implemented to generate a reduction in expenditures to a specific prescription drug class, rather than attempting to identify a savings to the overall Department's pharmaceutical budget. Some mechanisms to control costs involve certain restrictions on drugs while others involve obtaining utilization reports and information from contractors which can be used to determine other mechanisms to achieve reduction in expenditures. A summary of the estimated reduction in expenditures by drug class or by contractor realized from these mechanisms is listed below.

FY 05-06 estimated reduction in expenditure by drug utilization mechanism:

Leukotrienes	$0
Bactroban	$66,546
Promethazine	$15,135
Erectile Dysfunction drugs	$50,424
DUR Contract (annualized)	$2,285,750
TOTAL	$2,417,855

FY 06-07 estimated reduction in expenditure by drug utilization mechanism:

Zantac Liquid	$49,096
Tramadol	$7,240
Narcotic Analgesics	$2,608
Injectables	$478,310
Provigil	$122,243
ADHD drug class	$ 14,478
Advair	$228,578
TOTAL	$902,553