COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

December 1, 2015

The Honorable Beth McCann, Chair
Health, Insurance, and Environment Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative McCann:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the pharmacy utilization plan to the House Health, Insurance, and Environment Committee.

Section 25.5-5-506 (3)(b), C.R.S. requires the Department to report to the General Assembly's health committees and the Joint Budget Committee on the pharmacy plan utilization mechanisms the Department has implemented or will implement, the time frames for implementation, the expected savings associated with each mechanism, and any other information deemed appropriate no later than December 1 of each year.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/rml
Enclosure(s): Health Care Policy and Financing FY 2015-16 Pharmacy Utilization Plan

Cc: Representative Joann Ginal, Vice Chair, Health, Insurance and Environment Committee
Representative J. Paul Brown, Health, Insurance and Environment Committee
Representative Daneya Esgar, Health, Insurance and Environment Committee
Representative Steve Humphrey, Health, Insurance and Environment Committee
Representative Janak Joshi, Health, Insurance and Environment Committee
Representative Gordon Klingenschmitt, Health, Insurance and Environment Committee
Representative Lois Landgraf, Health, Insurance and Environment Committee
Representative Susan Lontine, Health, Insurance and Environment Committee
Representative Dianne Mitsch Bush, Health, Insurance and Environment Committee
Representative Dianne Primavera, Health, Insurance and Environment Committee
Representative Kim Ransom, Health, Insurance and Environment Committee
Representative Su Ryden, Health, Insurance and Environment Committee
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Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Jed Ziegenhagen, Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

December 1, 2015

The Honorable Millie Hamner, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Hamner:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the pharmacy utilization plan to the Joint Budget Committee.

Section 25.5-5-506 (3)(b), C.R.S. requires the Department to report to the General Assembly's health committees and the Joint Budget Committee on the pharmacy plan utilization mechanisms the Department has implemented or will implement, the time frames for implementation, the expected savings associated with each mechanism, and any other information deemed appropriate no later than December 1 of each year.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/rml
Enclosure(s): Health Care Policy and Financing FY 2015-16 Pharmacy Utilization Plan

Cc: Senator Kent Lambert, Vice-chair, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
Senator Kevin Grantham, Joint Budget Committee
Senator Pat Steadman, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Henry Sobanet, Director, Office of State Planning and Budgeting
Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting
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Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

December 1, 2015

The Honorable Dianne Primavera, Chair
Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Primavera:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the pharmacy utilization plan to the House Public Health Care and Human Services Committee.

Section 25.5-5-506 (3)(b), C.R.S. requires the Department to report to the General Assembly's health committees and the Joint Budget Committee on the pharmacy plan utilization mechanisms the Department has implemented or will implement, the time frames for implementation, the expected savings associated with each mechanism, and any other information deemed appropriate no later than December 1 of each year.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/rml
Enclosure(s): Health Care Policy and Financing FY 2015-16 Pharmacy Utilization Plan

Cc: Representative Jonathan Singer, Vice-Chair, Public Health Care and Human Services Committee
Representative Kathleen Conti, Public Health Care and Human Services Committee
Representative Jessie Danielson, Public Health Care and Human Services Committee
Representative Justin Everett, Public Health Care and Human Services Committee
Representative Joann Ginal, Public Health Care and Human Services Committee
Representative Janak Joshi, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Dominick Moreno, Public Health Care and Human Services Committee
Representative Brittany Petterson, Public Health Care and Human Services Committee
Representative Lang Sias, Public Health Care and Human Services Committee
Representative Max Tyler, Public Health Care and Human Services Committee
Representative JoAnn Windholz, Public Health Care and Human Services Committee
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Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

December 1, 2015

The Honorable Kevin Lundberg, Chair
Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Lundberg:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the pharmacy utilization plan to the Senate Health and Human Services Committee.

Section 25.5-5-506 (3)(b), C.R.S. requires the Department to report to the General Assembly's health committees and the Joint Budget Committee on the pharmacy plan utilization mechanisms the Department has implemented or will implement, the time frames for implementation, the expected savings associated with each mechanism, and any other information deemed appropriate no later than December 1 of each year.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/rml
Enclosure(s): Health Care Policy and Financing FY 2015-16 Pharmacy Utilization Plan

Cc: Senator Larry Crowder, Vice-Chair, Health and Human Services Committee
Senator Irene Aguilar, Health and Human Services Committee
Senator Beth Martinez Humenik, Health and Human Services Committee
Senator Linda Newell, Health and Human Services Committee
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Zach Lynkiewicz, Legislative Liaison, HCPF

INTRODUCTION

The Pharmacy Utilization Plan is required by 25.5-5-506(3)(b), C.R.S. (2014) which states:

(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 (Department) continues to pursue reductions in pharmaceutical expenditures by implementing several utilization mechanisms to control costs while ensuring access to medications for clients who need them. These mechanisms include enforcing limits on certain drugs, placing prior authorization requirements on certain drugs, and selecting drug classes for the Preferred Drug List (PDL). The Department is also considering other utilization mechanisms to determine if they would result in cost avoidance.

The Drug Utilization Review (DUR) Board, established by the Department, reviews drug utilization issues and makes recommendations to the Department to ensure utilization of prescription drugs is clinically appropriate and cost effective. The Department evaluates the issues identified by the DUR Board and implements utilization policies that are appropriate and will achieve cost savings. In addition, the Department has contracted with the University of Colorado School of Pharmacy (SOP) to provide additional DUR analysis and make recommendations to the Department and the DUR Board. The scope of the SOP and the DUR program has been increasing over the past years and now the contract has been expanded to include more clinical reviews and assistance with prior authorization reviews. The SOP continues to provide high quality utilization and clinical recommendations to guide policy decisions. This expansion is allowing the DUR program and the Department to address medications more proactively with clinical criteria. This is becoming more evident in both the prior authorization criteria and the PDL.

As an example, the DUR program in FY 2014-15 has provided in-depth analysis in the following areas:

- Naloxone and Buprenorphine Product Utilization
    - This analysis assessed Medicaid members who may benefit from a naloxone prescription to prevent opioid overdose versus the potential costs of products. Also, it characterized the usage patterns of members taking buprenorphine products in order to establish clinical appropriate usage. This analysis suggested prior authorization criteria for buprenorphine products, and recommended covering intranasal naloxone versus name brand products.
- Targeted Immune Modulator Utilization
    - This analyzed the patterns of use of the targeted immune modulators, the appropriateness of use, and the therapeutic response in members with rheumatoid

arthritis. The second part of this was to analyze the overall medical costs in patients receiving these drugs. The outcome of the analysis was a better characterization of this class of medications and better use of the clinical prior authorization criteria.

- Opioid High Utilizers
    - In past analyses, the DUR group has identified the risk of overdose to be 7-fold higher for those patients receiving > 200 morphine-equivalent doses (MED) of opiates. Using this cut-point for opiate use, we conducted two separate analyses to describe pre- and post- utilization patterns within 1) Medicaid members who initiated a long-acting opioid with > 200-250 MED per day without prior record of this strength or higher and 2) Medicaid members who initiated a long-acting opioid with > 250 MED per day without prior record of this strength or higher. The purpose here is to better understand what events have occurred that may have resulted in an increased use of opioid and look for commonalities between members.
- Mini-modules
    - These are smaller analyses that are done by the DUR program throughout the year. Some examples are as follows:
        - The use of L-methyl folate for depression
        - The use of Fish Oil outside of FDA approved indication
        - Characterization of overutilization of Proair inhalers
        - Detail of a new drug to treat cystic fibrosis
        - Assessment of bleeding associated with anticoagulants

Regarding the cost avoidance analysis contained within this Report, the Department analyzes the fiscal impact of the utilization control mechanisms by examining expenditure trends at the therapeutic class level. This captures substitution effects *within* drug classes, but does not always capture substitution effects *between* drug classes. The cost avoidance from the implementation of a prior authorization on specified drugs in a drug class may cause clients to shift to a substitute drug from a different therapeutic class instead of another drug in the same therapeutic class. The increase in the utilization for drugs in other therapeutic classes is not always measurable. This is seen with drug products having multiple approved uses, or in the instance of drugs which are prescribed off-label (for indications which are not approved by the Food and Drug Administration).

The Department's more proactive approach to the PDL and prior authorization criteria is changing the way fiscal impact is measured. The traditional method is to use historical utilization trends to extrapolate the continued medication use without criteria, and then compare to the actual use with criteria in place. When criteria are added to drugs as they are coming to the market, there is no previous utilization to assess utilization or financial impact. The DUR program tries to target high cost drugs to ensure that utilization is appropriate upon entering the marketplace. The Department believes that having clinical criteria on high-cost drugs as they come to market results in more appropriate utilization, which also results in better cost avoidance. Unfortunately, the Department does not have a reliable method by which to measure the full financial impact when there is no data with which to infer what the utilization would have been without the criteria in place. This holds true with the PDL as well, due to the fact that most of the classes with evident cost savings

associated are already a part of the PDL. The new capabilities of the pharmacy and DUR program are now providing pre-emptive mechanisms that catch utilization issues before they arise and require intervention.

PLAN UTILIZATION MECHANISMS PREVIOUSLY IMPLEMENTED

In the sections that follow, the Department describes its estimates of the fiscal impact of utilization control mechanisms implemented in or prior to FY 2014-15. It is important to recognize that market factors the Department cannot account for in its analysis likely influence the fiscal impact achieved by the implementation of utilization control mechanisms. Factors may 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, or new studies regarding the effectiveness of the drug. This is particularly true for prior authorizations that were implemented more than a year ago. The Department does not believe it is possible to accurately predict the potential cost avoidance after a prior authorization has been implemented for more than a year.

Preferred Drug List

Governor Ritter signed Executive Order D 004 07 in January 2007, establishing a preferred drug list (PDL) program for Colorado Medicaid. The purpose of this program is to provide clinically appropriate medications to Medicaid clients while decreasing expenditures on pharmaceuticals. This involves selecting drugs based on safety, cost-effectiveness and clinical outcomes from classes of medications where there are multiple drug alternatives available. Since implementation of the PDL, the majority of the Department's Pharmacy Utilization Plan has switched from individual drug prior authorization mechanisms to implementing drug classes on the PDL.

The PDL achieves savings by designating preferred drugs for which migration to a more cost-effective drug and/or collection of supplemental rebates from pharmaceutical manufacturers is possible. Supplemental rebates are rebates above the federally required minimum rebate level, which manufacturers offer to the Department in exchange for preferred status on the PDL. It is difficult to determine the exact amount of savings from the PDL that comes from supplemental rebates versus migration to preferred drugs for each drug class; however, the Department is able to provide aggregate level information. For FY 2014-15, the Department collected $14,847,277 in total supplemental rebates.

In some cases, the analysis indicates that supplemental rebates do not always offset the increased utilization and price of the preferred drug. The analysis does capture utilization shifts to other drugs, including higher cost newly FDA approved agents within the same drug class. It is important to note that the PDL is not a formulary. Any drug that meets the Federal requirements for a covered outpatient drug must have coverage available, and this coverage is included in the analysis.

Generic utilization is often viewed as a cheaper alternative to branded products. This is not always the case, especially in the first year of entrance to the marketplace. There are a few factors that can make the brand less expensive than the generic. Pursuant to federal law, the Department receives rebates for drugs covered, the federally required minimum rebate. The branded product can have a substantial federally-mandated rebate which makes the net cost significantly lower than any generic equivalent. Another factor that helps set price of generic drugs is the number of companies

that are producing the drug. When more companies are producing the product, the price will be driven down quicker. The Department does try to forecast the financial impact of generics being introduced to the market, but it is difficult to predict. In some cases, shifting to generic utilization by way of the PDL will actually cause expenditures to rise.

PDL Classes Updated in FY 2014-15

With the maturity of the PDL, there are already a large number of drug classes on the PDL and many of these classes have stabilized, thus limiting their capacity for additional savings. The Department generally adds new drug classes to the PDL on a quarterly basis. Existing drug classes are re-evaluated annually thereafter. For the purpose of this report, PDL reporting will be limited to those classes which have been added or changed significantly within the past two years, offering opportunity for cost avoidance. The cost avoidance can come from both the collection of supplemental rebates and/or the reduction of utilization of more expensive alternatives.

Insulin – This class was implemented on the PDL in April of 2014. The estimated cost avoidance for FY 2014-15 totals $851,021.

Testosterone Products – This class was originally implemented July 2014. The estimated cost avoidance for FY 2014-15 totals $43,365.

Inhaled Corticosteroid Combinations – This class was originally re-reviewed and changed effective July 2014. The estimated cost avoidance for FY 2014-15 totals $418,970. This cost avoidance is due to the change in preferred products which had become more expensive to the Department over the previous year.

DPP-4 Inhibitors – This class of diabetes drugs was originally re-reviewed and changed effective October 2014. The estimated cost avoidance for 2014-15 totals $548,872. This cost avoidance is due to the change in preferred products which had become more expensive to the Department over the previous year.

Growth Hormones – This class was re-reviewed and changed effective April 2015. The estimated cost avoidance for FY 2014-15 totals $890,047.

The overall PDL cost avoidance for FY 2013-14 is $2,752,275.

Prior Authorizations (PA) Implemented

Synagis® (palivizumab): The American Academy of Pediatrics published their updated recommendations for the use of palivizumab against respiratory syncytial virus (RSV) on July 28, 2014. The result of these newer recommendations is that fewer patients will need palivizumab throughout the season. New prior authorization criteria based on these recommendations were put into effect in 2014-15. This cost avoidance number was calculated by comparing the utilization trend of 2014-15 to previous year's utilization.

FY 2014-15 estimated cost avoidance for Synagis®: $3,803,144

Copaxone 40mg Injection (glatiramer acetate): This drug is on the PDL to treat multiple sclerosis. However the most recent savings from this drug comes from drug coverage based on strength. This drug has another strength of 20mg that is significantly cheaper to the Department. Therefore, the 40mg injections have a prior authorization on them to avoid unnecessary costs.

FY 2014-15 estimated cost avoidance for Copaxone 40mg: $330,422

Opioids: Opioid products are split into two categories for the Medicaid pharmacy benefit. Long-acting products are on the PDL and the short-acting products are not. In August of 2014, a policy was implemented to limit the quantity of short-acting opioids per member per month to 120 units per 30 days. This is to ensure appropriate treatment of chronic pain and to reduce the over-utilization of these products. The result of this was the reduction of the average number of units of short-acting products received per member. There was an increase in long-acting use, but this is attributed to more appropriate management.

FY 2014-15 estimated cost avoidance for Opioids: $628,911

Treatments for Hepatitis C

As reported in the FY 2013-14 report, the landscape of Hepatitis C treatments has changed dramatically in the past few years, beginning in December 2013 with the FDA's approval of Sovaldi (sofosbuvir). Since then, there are now several products on the PDL with clinical prior authorization criteria. Due to the complex nature of this area, it is difficult to estimate a cost avoidance. The costs reported below are based on actual approvals and denials of prior authorization requests. The cost of approvals is from actual reimbursement amounts for the drug claims. Cost avoidance is reported based on what would have been spent if all of the submitted prior authorizations were approved. There is also an assumed population that is not factored into this, which is members who have not submitted a request for prior authorization but who have a diagnosis of Hepatitis C. When the Department last ran the number of members with a Hepatitis C diagnosis, it was found that 8499 members had such a diagnosis.

These amounts are reported as from the beginning of the coverage period of these drugs. This includes claims going back to the end of calendar year 2013 and concluding at the end of June 2015.

Cost of approvals: $11,304,908

Estimated cost avoidance: $49,814,827

The Department believes this infectious disease is a public health concern. Because of the potential devastation of Hepatitis C, treatment for people with Hepatitis C is important and we have targeted those at highest risk of developing complications. The Department is responsible for providing health care for our members while at the same time being fiscally responsible to the taxpayers of

the State of Colorado. With respect to the prevalence of Hepatitis C and the high cost of treatment, balancing these two charges continues to be very challenging.

We need to be stewards of our limited state resources. Hepatitis C is a slow moving disease and only a small number of people who contract Hepatitis C progress to liver failure and death. The CDC reports a mortality rate for Hepatitis C of 5.0/100,000, as of 2013. The Department's solution is to treat the members that have the most advanced disease and are likely to respond to treatment, and those with an anticipated liver transplant in order to avoid an infection of the transplanted liver. Aside from cost, one of the main reasons the Department has been cautious with approvals of these drugs is safety. It is a fairly standard practice for us to limit utilization of drugs newly released to market because of the limited long-term safety studies that exist. It is not uncommon to find out safety information years after drugs are approved by the FDA, due only to post marketing information. These treatments are still very new and there have been recent FDA warnings reported for a couple of the agents. Recently, it was announced that there was a significant drug-drug interaction that caused heart arrhythmias only 16 months after the first treatment agent was approved. It was also announced that liver toxicities, which can lead to death and transplants, were announced only 10 months after another treatment agent was approved by the FDA.

Other Prior Authorizations Implemented

During FY 2014-15 there were also prior authorization criteria put in place for many other drugs. The cost analysis was unable to show any cost avoidance due to the extremely low utilization of these medications. The prior authorization criteria for each medication was implemented at or near the time of market release of these expensive drugs, and so there is insufficient data to track utilization trends or cost avoidance. The Department believes that placing prior authorization criteria on these medications as they enter the market promotes proper utilization of these drugs and results in cost-avoidance by preventing any inappropriate use.

PLAN UTILIZATION MECHANISMS TO BE IMPLEMENTED IN FY 2015-16

The Department's focus will continue to be split between adding/managing PDL classes, educating providers regarding updates and monitoring plan utilization while implementing criteria to support safe, appropriate and cost effective use of drug products.

The Department's DUR contractor continues to provide high quality drug utilization review services. The clinically trained pharmacists who provide services under this contract offer clinical perspective and opportunities to ensure efficient utilization of the pharmacy benefit. The contract was expanded for FY 2014-15 to allow for additional clinical reviews and assistance with prior authorization reviews and other related activities. As a part of this contract expansion, the DUR program is now contracting with child psychiatrists from Colorado Psychiatric Access and Consultation for Kids (CPACK) to assist in complex issues related to psychiatric medicine for children. In addition, the Department is also contracted with a pain specialist to assist in

matters concerning pain management. This will help the Department to better understand the complex cases often reviewed for prior authorization. It will also help to have insight into those areas in which the Department often is crafting policy or working to educate providers.

Colorado Medicaid underwent significant expansion in FY 2013-2014. The DUR program is planning on focusing some analysis on the newer expansion population in the coming year. This has changed the dynamics of the Colorado Medicaid members, and so further description is needed in order to appropriately manage the pharmacy benefit.

The DUR program continues to help the Department focus on overutilization of opioid pain-killers. The overdose death rate continues to worsen across the US, and it is always a concern in Colorado. The Department works closely with all stakeholders in Colorado to address this ongoing epidemic. The overutilization issue continues to be identified from multiple sources as a top priority in healthcare today. The Colorado Consortium for Prescription Drug Abuse Prevention is a statewide organization that includes representation from the Department and the DUR program. There are several initiatives that have come out of this collaboration to help the State of Colorado better manage the problem of prescription drug abuse.

The State Auditor's Office recently identified some opioid overutilization within the Colorado Medicaid population. This population was brought to the Department's attention, and is now included as part of the target populations for reducing drug abuse and overutilization. There are many ways that the Department and the DUR Program identify these populations.

With this in mind, Colorado will need to analyze its specific patient-level opiate utilization patterns in those who may be using high dose opiate medications. The Department must keep in mind the recent data reported in the U.S. showing strong correlations between reducing prescription drug availability and increasing the use of heroin. The only way to try and address this issue fully is to have a multi-faceted approach that includes payers reducing high volumes of these medications when unnecessary, training providers to appropriately treat chronic pain, give pharmacists tools to address these patients and much more.

This has led the Department to implement a morphine equivalent limitation policy that is scheduled to begin early in 2016. The Department is continuing to develop a policy for opioid-containing products and methadone that will apply a limit on the total daily milligrams of opioids and methadone that can be dispensed using morphine equivalents conversion calculations. Under this new policy, the daily milligrams of morphine equivalents for each opioid containing agent (including both long-acting and short-acting) and methadone that a member is currently taking will be added together. Prescriptions that exceed the maximum daily limit of 300 milligrams of morphine equivalents will be denied. The DUR Program will continue to adapt its retrospective analysis program to the needs of the Department and the State. This program identifies potentially inappropriate utilization issues and provides informational letters to the providers involved.

One of the biggest problems in Colorado is the lack the providers who are specifically trained to treat chronic pain and addiction problems. Patients with addiction issues related to chronic pain are in dire need of someone to help them appropriately manage that addiction. Simply denying

claims for high doses of pain medications can cause many, potentially life-threatening, issues for these patients. One initiative the Department has implemented to combat this is Project ECHO. This is a program that provides targeted education to providers who enroll in the program, as well as advice from specialists on specific patient cases. This will allow more providers in the State to be familiar with these complex cases and problems.

SUMMARY

The Department has implemented a number of drug utilization mechanisms to control costs such as adding classes to the PDL and requiring prior authorizations for drugs. In most sections of this report, the Department identifies the utilization mechanisms that have been implemented to generate cost avoidances 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 supplemental rebates from manufacturers for individual drugs.

A summary of the estimated avoided costs is listed below. Please note that cost avoidance has been reported for relevant classes that have been recently implemented or updated. Drug classes without significant change still contribute to overall cost avoidance because of the Supplemental Rebate contracting process as is shown below. The methodology for calculating the associated savings is continuing to change, and this has made it more difficult to calculate the projected cost avoidance for the future; therefore, the tables do not show estimated PDL cost avoidance for FY 2015-16.

Total Supplemental Rebates Collected (actual rebate collected during FY 2013-14 for all PDL classes)	**$**14,847,277

Summary of Savings Achieved Through Utilization Control Mechanism	**FY 2014-15**
Preferred Drug List Updates	$2,752,275
Prior Authorization Policy	$54,577,304
Total	**$57,329,579**

Preferred Drug List Savings by Drug Class	FY 2014-15
Insulins	$851,021
Testosterones	$43,365
Inhaled Corticosteroid Combinations	$418,970
DPP-4 Inhibitors	$548,872
Growth Hormones	$890,047
Total Preferred Drug List Update Savings	**$2,752,275**

Prior Authorization Policy Savings by Drug Class	FY 2014-15
Synagis	$3,803,144
Opioids	$628,911
Copaxone	$330,422
Hepatitis C Drugs	$49,814,827
Total Prior Authorization Savings	**$54,577,304**