



Office of Pharmacy Services, Medicaid Pharmacy Program

Drug Use Review (DUR) Board

Thursday, March 5, 2026

Meeting Minutes

DUR Board: A. Cotton, C. Dowd-Green, L. Drake, S. Edwards, M. Gendi, J. Merrey, B. Murray, K. Pirollozzi, K. Wagner

Maryland Department of Health: A. Alexandrou, M. Joglekar, L. Karanja, N. Purohit, M. Rowson, S. Roberson, D. Shah

Prime Therapeutics: A. Wherley

Conduent State Healthcare: J. Paul

Acentra Health: L. Friendak, S. Zubay

Owl Creek Consulting: L. Adelhardt

The Maryland Medicaid Drug Use Review (DUR) Board virtual meeting was called to order at 9:18 a.m. on Thursday, March 5, 2026, by the chair, Dr. Dowd-Green. The virtual meeting format and participation instructions were presented. A roll call was conducted of the DUR Board members, affiliated staff, and presenters in attendance.

Minutes

Minutes from the December 4, 2025, DUR Board meeting were approved as presented.

Office of Pharmacy Services (OPS)

As of January 1, 2026, the Maryland Medicaid Fee-for-Service (FFS) Program, including all nine Managed Care Organizations (MCOs), became one of the participating State Medicaid Programs in the Cell and Gene Therapy (CGT) Access Model and covers both the Lyfgenia and Casgevy therapies. Participating in the Model gives Maryland stronger financial protections and potential cost savings, which can help support patients with this disorder and improve access to advanced therapies.

The Maryland Medicaid Fee-for-Service (FFS) Program and all nine MCOs started covering Wegovy (Semaglutide) injection for its newly approved MASH (noncirrhotic metabolic dysfunction-associated steatohepatitis), formerly known as NASH (nonalcoholic steatohepatitis), as of December 18, 2025. Currently, pursuant to COMAR 10.09.03.05(A)(14), medications for

weight management and/or weight control are not covered by the Maryland Medicaid FFS program.

Board members were encouraged to refer to the OPS Medicaid Program's website at <https://health.maryland.gov/mmcp/pap/Pages/paphome.aspx> or use <https://bit.ly/43FFACr> to stay current on the latest announcements.

Unified Corrective Managed Care, A.K.A. CMC, Lock-in Program Update:

The Program is actively monitoring the aberrant usage of controlled substances by enrollees under the State plan, and this Program is working as anticipated and facilitating improvement in appropriate practices. As of February 6, 2026, a total of 246 participants are locked in the CMC lock-in Program with 222 providers, out of which only 10 members have been locked-in with the FFS Program, and the rest are locked-in among the nine MCOs. The Program's goal is the well-being of its members and to provide clinically appropriate and cost-effective therapies to all participants in a timely manner.

The Maryland Medicaid Office of Pharmacy Services provides live continuing medical education (CME) for prescribers and continuing education (CE) for pharmacists every year at no cost. The Department has planned a virtual four-hour live program on April 18, 2026, at 9:00 am. The presenters are slated to deliver "Diagnosis Evidence-Based Treatment Measures" and "Management of Anxiety and Depression". Visit https://mmpipi.com/live_meetings.htm to register and take advantage of receiving CME/CE credits to fulfill licensing requirements.

Thank you to all DUR board members for their expertise and time to participate on this Board. Any queries should be brought to the Office of Pharmacy Services.

Conduent State Healthcare, LLC

Conduent presented summaries for therapeutic duplication alerts for the use of benzodiazepine and clonazepam, Preferred Drug List (PDL) prior authorization requests, and prospective drug use review (ProDUR) edits for the fourth quarter of 2025.

Therapeutic Duplication Alerts – Benzodiazepines and Clonazepam

Regarding therapeutic duplication of benzodiazepines and clonazepam, Conduent reported 6,588 alerts for 702 participants with 1,051 overrides entered at the Point-of-Sale by the pharmacy provider for 500 participants, resulting in an override rate of 71%. This is slightly higher than the previous quarter.

PDL Prior Authorization Requests

For the fourth quarter of 2025, there were 3,516 new PDL PAs, of which 3,120 were for the top ten therapeutic classes. This accounts for 88.7% of the total new PDL PAs, a slight increase

compared to the previous quarter. Stimulants and Related Agents ranked the highest. Opioid Use Disorder Treatment returned to the top ten therapeutic classes, replacing Skeletal Muscle Relaxants. A full listing of all PDL prior authorization requests for the fourth quarter was presented to the Board.

Prospective Drug Use Review (ProDUR)

- 1) **Therapeutic Duplications**
Regarding the top 20 therapeutic duplications, Conduent reported 9,322 alerts and 24,844 overrides, with 25.7% of the total in conflict, which is consistent with previous quarters. Antidepressants continue to account for more than 60% of the top 20 therapeutic duplication alerts.
- 2) **Early Refill**
Regarding the top 20 drugs for early refill, Conduent reported 35,362 alerts and 2,533 overrides, with 28.2% of the total in conflict, which is comparable to the previous quarter. Antidepressants, Antipsychotics, and Gabapentin account for more than 75% of the alerts.
- 3) **Drug-Drug Interactions**
Regarding drug-drug interactions, Conduent reported 22,656 alerts and 12,068 overrides, with 35.3% of the total in conflict, similar to the previous quarter. Antidepressants and Antipsychotics account for more than 85% of the alerts.
- 4) **Conflict, Intervention, and Outcome**
The most frequently reported intervention and outcome codes entered by the pharmacy at the Point-of-Sale were M0, that the prescriber was consulted, and 1G, approved by the prescriber. Therapeutic duplication claims are denied at POS and require conflict, intervention, and outcome codes to be entered by the pharmacy provider to get a paid claim. The early refill edit cannot be overridden by entering conflict, intervention, and outcome codes at POS, which is why the numbers are much lower than those seen for therapeutic duplications. Early refill is a hard edit that requires a call to the Call Center for prior authorization.
- 5) **Cost Avoidance**
Cost avoidance numbers were reported as attributed to the claims that were posted DUR edits. Early refill is the only DUR edit that is a true denial. The cost avoidance values reported for the other DUR edits are based on reversed claims.
- 6) **Call Center**
The call center totals for the fourth quarter show a slight decrease in faxes and in-call volume compared to the previous quarter. All abandoned calls were less than 1% of the calls.

Acentra Health

Acentra Health presented a review of action items, an overview of active interventions, a retrospective DUR (RDUR) intervention summary for the fourth quarter of 2025, and future RDUR interventions for the Maryland Medicaid FFS population.

Action Items

Outcomes of RDUR interventions for the fourth quarter of 2025 were presented. The process is initiated during the profile review by a clinical pharmacist. Participants identified as having a therapeutic issue are flagged, and educational intervention letters are sent to both prescribers and pharmacy providers. The identified participants are reassessed after a six-month suppression period to determine if there has been a change in prescribing behaviors.

Active Interventions

- 1) Duplicate sedative/hypnotic use (quarterly)
This intervention had another successful quarter for resolving therapeutic duplication of sedative-hypnotics. Nine recipients identified on the initial profile review met the criteria for duplicate therapy again in the follow-up period. Thus, approximately two-thirds had either one or both of the duplicate medication(s) discontinued. This continues to be a successful intervention, and it is recommended to continue the current quarterly schedule with six-month follow-up data reported.
- 2) Concurrent use of gabapentin and pregabalin (quarterly)
Results for this intervention showed high effectiveness. There were 12 recipients identified on the initial profile review meeting criteria for concurrent therapy in the follow-up period. This quarter saw a 17% recurrence rate, which was within the average recurrence rate of 15-30%. This continues to be an effective intervention, especially considering that gabapentin has not yet been reported under the Prescription Drug Monitoring Program (PDMP). It is recommended to continue quarterly with six-month follow-up data reported.
- 3) Concurrent use of an opioid and medium-high dose gabapentin (quarterly)
Results for this intervention showed a 43% reduction in those identified as using an opioid and medium-high dose gabapentin. This was reflected by discontinuation of opioids, lowered dose of gabapentin, or discontinuation of gabapentin in the six months after the educational intervention letters were sent. It is recommended to continue this quarterly intervention with six-month follow-up data reported.
- 4) Concurrent opioid and duplicate skeletal muscle relaxants (quarterly)
This intervention addressing the use of concurrent opioid and duplicate skeletal muscle relaxants showed three recipients identified on initial profile review that met criteria for

concurrent therapy again in the follow-up period. Thus, approximately two-thirds had either one or both of the opioid or skeletal muscle relaxant medications discontinued. It is recommended to continue this quarterly intervention with six-month follow-up data reported.

The following active interventions are mandated by the SUPPORT Act. It is recommended to continue all SUPPORT Act interventions quarterly with a six-month follow-up.

- 1) Naloxone use (quarterly)
These patients are on chronic opioid therapy, have a history of substance use disorder, or have a history of overdose, and do not have a naloxone prescription on file. This was a successful intervention, as there was a slightly lower number of patients who flagged for this intervention this quarter, meaning more patients with chronic opioid therapy are being prescribed naloxone.
- 2) Concurrent use of opioid and benzodiazepine (quarterly)
Results from this intervention showed a 53% recurrence rate for recipients identified as using both an opioid and a benzodiazepine, which means that almost half of the patients saw concurrent therapy discontinued during the post-intervention period.
- 3) Concurrent use of opioid and antipsychotic (quarterly)
Results for this intervention showed recurrence rates for concurrent use of opioid and antipsychotic at 53%, meaning almost half had concurrent therapy discontinued.

Retrospective DUR (RDUR) Interventions

During the fourth quarter of 2025, active retrospective interventions were conducted with results as follows. All interventions are run quarterly, with six-month outcome data reported to the Board quarterly, except for the triple therapy intervention (concurrent use of an opioid, benzodiazepine, and carisoprodol), which is run biannually. The triple therapy intervention was not run this cycle, so there are no results to report for this intervention.

- 1) Duplicate sedative use
There were 27 participants flagged for this intervention, and 67 intervention letters were mailed, with an average response rate of 5% (prescribers) and 20% (pharmacies). The top prescriber response was shared between “Prescriber discontinued medication(s)” and “Patient has an appointment to discuss therapy”. The top pharmacy response was “Spoke to prescriber; expect modification in therapy”.
- 2) Concurrent use of an opioid and medium-high dose gabapentin
There were 85 participants flagged for this intervention, and 307 letters were mailed, with a response rate of 5% (prescribers) and 14% (pharmacies). The top prescriber

response was “Provider did not prescribe drug attributed to them”. The top pharmacy response was “Pharmacist will counsel patient at next visit”.

- 3) Concurrent use of gabapentin and pregabalin
A total of 122 participants were flagged for this intervention, and 362 intervention letters were mailed, with a response rate of 10% (prescribers) and 20% (pharmacies). The top prescriber response was “Prescriber discontinued medication(s)”. The top pharmacy response was “Spoke to prescriber, expect modification in therapy”.
- 4) Concurrent use of an opioid and duplicate skeletal muscle relaxant
There were 9 participants flagged for this intervention, and 25 intervention letters were mailed, with a response rate of 0% (prescribers) and 11% (pharmacies). There was no prescriber response. The top pharmacy response was “Spoke to prescriber, expect modification in therapy”.

The following interventions are conducted as required by the SUPPORT Act.

- 5) Naloxone use
There were 14 participants selected for this intervention, and 34 letters were mailed, with a response rate of 0% (prescribers) and 13% (pharmacies). There was no prescriber response. The top pharmacy response was shared between “Spoke to prescriber, expect modification in therapy” and “No change in therapy, pharmacist disagrees”.
- 6) Concurrent use of opioid and benzodiazepine
A total of 93 participants were selected for intervention, and 311 letters were mailed, with a response rate of 7% (prescribers) and 14% (pharmacies). The top prescriber response was shared between “Provider tried to modify therapy, symptoms reoccurred” and “Provider did not prescribe drug attributed to them”. The top pharmacy response was “Pharmacist will counsel patient at next visit”.
- 7) Concurrent use of opioid and antipsychotic
There were 89 participants flagged for intervention, and 307 intervention letters were mailed, with an average response rate of 4% (prescribers) and 12% (pharmacies). The top prescriber response was shared between “Provider did not prescribe drug attributed to them” and “Patient has an appointment to discuss therapy”. The top pharmacy response was “Pharmacist will counsel patient at next visit”.

Follow-up occurred for those providers responding with “Provider did not prescribe drug attributed to him/her” to confirm that all providers prescribed at least one of the medications included in the intervention. The interventions resulted in reduced prescriptions overall, showing the effectiveness of the intervention program.

Future Retrospective DUR Intervention

Board members were invited to suggest new medications to be considered for clinical criteria maintenance and send recommendations to Lynn Frendak.

Other Business

As noted, the next continuing medical education and continuing education seminar hosted by the MDH Office of Pharmacy Services will cover *Anxiety & Depression* on Saturday, April 18, 9 a.m. – 1 p.m and offer 4.0 CME/CE credits. Board members will receive an email invitation and are encouraged to register and share the invitation with colleagues.

The next DUR Board meeting will be held on June 4 at 9:15 a.m. Future 2026 dates include September 3 and December 3, 2026.

Board members were thanked for their service to the state of Maryland and the Maryland Department of Health.

There being no additional business, the meeting was adjourned at 10:00 a.m.