California Workers' Compensation Institute

Spotlight Report

California's Proposed Workers' Compensation Formulary

Part 1: A Review of Preferred and Non-Preferred Drugs

By Alex Swedlow and Steve Hayes August 2016

In October 2015, Governor Brown signed Assembly Bill 1124 mandating that the California Division of Workers' Compensation (DWC) adopt a prescription drug formulary for the California workers' compensation system. This bill had been introduced by Assemblyman Henry Perea after studies by the California Workers' Compensation Institute (CWCI) and the Workers Compensation Research Institute (WCRI) estimated that depending on how it was structured and implemented, a state-mandated workers' compensation formulary could save 8 to 42 percent of total drug spend,[1,2] while simultaneously raising the quality of care for injured workers and reducing frictional costs in the system.

AB 1124 called for the DWC Administrative Director to meet and consult with stakeholders regarding the development of a drug formulary, and to publish at least two interim status reports prior to adopting the formulary by July 1, 2017. In addition, in order to allow a safe transition to formulary medications, the bill required the formulary to be phased in for workers injured before its effective date. It required the DWC to update the formulary on at least a quarterly basis without going through the formal rulemaking process. It also required the Administrative Director to establish and consult with an independent pharmacy and therapeutics committee to review all available evidence about the safety and effectiveness of drugs in order to inform the updating of the evidence-based drug formulary.

The intent of AB 1124 was two-fold: to ensure that medications provided to injured workers meet evidence-based standards in regard to frequency, duration, strength and appropriateness; and to reduce delays and friction costs associated with utilization review and independent medical review. To a great extent, the success of the formulary in meeting these goals will hinge on the final regulations, and how they fill in the many important details. Over the past year, the DWC commissioned a RAND study[3] and gathered input from various stakeholders and

[1] Swedlow, A. and Hayes, S. "Are Formularies a Viable Solution to Controlling Prescription Drug Utilization and Cost in California Workers' Compensation." CWCI Report to the Industry. October 2014.
[2] Thumala, V. and Liu, T. Impact of a Texas-Like Formulary in Other States. June 2014.
[3] Wynn, B., Buttorff, C., Meza,E., Taylor, E.A., Mulcahy, A., Implementing a Drug Formulary for California's Workers' Compensation Program, RAND, August 2016. (access at http://www.rand.org/pubs/research_reports/RR1560.html)

industry experts. On August 26, 2016 the DWC released a draft of its proposed regulations, including a Medical Treatment Utilization Schedule (MTUS) Preferred Drug List.[4]

The draft regulations reflect a broad effort by the Division to streamline the delivery of effective care to injured workers by implementing the formulary and the 30-day pass-through utilization review (UR) provisions proposed under Senate Bill 1160 (Mendoza).[5] The focus of the formulary is on prescription medications dispensed for outpatient use. Drug treatment under the formulary is governed by the simple classification of a medication designated as either "Preferred" (not requiring authorization through prospective review if prescribed in accordance with the MTUS) or "Non-Preferred" (requiring authorization through prospective review prior to prescribing or dispensing).[6] Any drug not designated Preferred or Non-Preferred is still subject to authorization through prospective utilization review.

In addition to the "Preferred" and "Non-Preferred" classifications, some additional flexibility is built into the rules. For example, while otherwise designating all opioids as "Non-Preferred Drugs," and thus subject to prospective review, the draft regulations permit a limited first fill of some opioid medications without prospective review if the medications are prescribed or dispensed at an initial visit within seven days of the date of injury, and the opioid is prescribed in accordance with the MTUS Guidelines. The rules affirm that drugs prescribed or dispensed to treat a work-related injury are considered to be medical treatment under Labor Code section 4600, and thus are subject to the MTUS Guidelines and rules. Those Guidelines and rules include provisions regarding the presumption of correctness ascribed to drug treatment provided in conformity with the MTUS Guidelines, as well as the methods for rebutting that presumption with a preponderance of scientific medical evidence, or for treating a condition or injury not addressed by the MTUS.

The authors conducted a study to identify the potential impact that the proposed formulary will have on prescription drug utilization in California workers' compensation. The study sought to:

1. Measure the percentage of prescriptions and dollars classified by the formulary as Preferred or Non-Preferred, as well as the percentage of prescriptions and dollars for drugs currently used in California workers' compensation that are not listed in the formulary as Preferred or Non-Preferred;
2. Identify the therapeutic drug groups and drug ingredients that the formulary will most impact; and
3. Estimate the impact of the recommendation to allow workers to receive drugs as a "First-Fill" following an injury, without requiring prior authorization.

[4] DWC Forum - Implementing AB 1124 Drug Formulary and update of MTUS guidelines, www.dir.ca.gov/dwc/ForumDocs/Implementing-AB-1124-Drug-Formularyand-update-of-MTUS-Guideline/Implementing-AB-1124-Drug-Formularyand-update-of-MTUS-Guidelines.htm

[5] The "pass-through" provisions of SB 1160 (Mendoza), approved by the State Assembly on August 25, 2016, would limit prospective utilization review in the first 30 days of a claim for care provided by an "employer-directed provider," such as a clinician in an employer's medical provider network. The bill does, however, contain exceptions to the "no UR" rule, including non-preferred medications and those drugs not covered by the formulary.

[6] See page 9 for a glossary of these and other terms used in the formulary and in this report.

This Spotlight Report summarizes the study findings. It represents the first in a series of reports presenting analyses of key features of the proposed formulary.

Data Sources and Methods

In this analysis, as in its October 2014 study, the Institute used the most recent data available on the volume, mix and cost of prescription drugs in the California workers' compensation system to estimate the potential savings associated with the draft formulary.

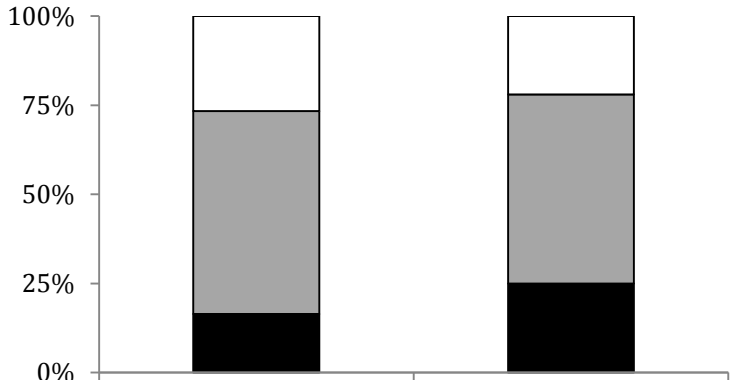
Using the CWCI Industry Research Information System (IRIS)[7] database, the authors compiled a sample of 1.2 million prescriptions dispensed to California injured workers between January and December 2014. Payments for those prescriptions totaled $155 million. The prescriptions in the sample were compared to the draft regulations and the proposed MTUS Preferred drug list, which was based upon the American College of Occupational and Environmental Medicine's (ACOEM) pharmaceutical formulary.[8]

[7] IRIS is CWCI's proprietary database containing data on employee and employer characteristics, medical service data, benefits, and administrative costs on approximately 5 million California workers' compensation claims.
[8] American College of Occupational and Environmental Medicine. Reed Group, MDGuidelines, www.mdguidelines.com/

Findings

Using the sample of 1.2 million prescriptions from the IRIS database, the authors first calculated the percentage of the prescriptions that would have been classified as either Preferred or Non-Preferred. All other drugs not identified as Preferred or Non-Preferred were not on the formulary drug list and would still be subject to prospective utilization review.

Exhibit 1: Percentage of Prescriptions and Associated Payments by Formulary Category



	Scripts	Payments
Preferred	26.6%	22.0%
Non-Preferred	57.0%	53.1%
Not Listed in MTUS	16.4%	24.9%

Almost 27 percent of the prescriptions and 22 percent of their associated payments would be classified as Preferred drugs in the formulary list. More than 73 percent of prescriptions and 78 percent of the associated payments would be either Non-Preferred or Not on the Formulary Drug List.

All pharmaceutical drugs can be classified based on their broad therapeutic group, active ingredient (i.e., generic drug name), and other characteristics. The authors summarized the 1.2 million prescriptions by Therapeutic Drug Group. Exhibit 2 shows the distribution of drugs in each of the top 20 drug groups across the three formulary categories. Together these top 20 drug groups represent 93.5 percent of all drugs dispensed in the California workers' compensation system.

Exhibit 2: Top 20 Therapeutic Drug Groups—Percentage of Total Prescriptions Sorted by Volume

Therapeutic Drug Group	Preferred	Non-Preferred	Not Listed in MTUS
Opioid Analgesics (27.0%)	0.0%	100.0%	0.0%
Anti-Inflammatory Analgesics (19.2%)	96.5%	3.1%	0.4%
Musculoskeletal Therapy (9.4%)	0.0%	98.8%	1.2%
Ulcer Drugs (7.0%)	99.3%	0.0%	0.7%
Anticonvulsants (6.4%)	0.0%	98.4%	1.6%
Antidepressants (5.8%)	0.0%	89.8%	10.2%
Dermatologicals (5.3%)	0.0%	89.2%	10.8%
Hypnotics/Sedatives/Sleep Disorder (2.4%)	0.0%	0.0%	100.0%
Antianxiety Agents (1.9%)	0.0%	45.6%	54.4%
Bulk Chemicals (1.3%)	0.0%	0.4%	99.6%
Antihypertensives (1.0%)	0.0%	7.3%	92.7%
Corticosteroids (1.0%)	0.0%	63.7%	36.3%
Laxatives (1.0%)	0.0%	0.0%	100.0%
Antihyperlipidemics (0.9%)	0.0%	0.0%	100.0%
Beta Blockers (0.9%)	0.0%	0.0%	100.0%
Cephalosporins (0.8%)	0.6%	63.6%	35.8%
Non-Narcotic Analgesics (0.7%)	61.5%	34.2%	4.2%
Antipsychotics/Antimanic (0.6%)	0.0%	0.0%	100.0%
Ophthalmic Agents (0.5%)	41.1%	16.2%	42.7%
Antidiabetics (0.5%)	0.0%	0.7%	99.3%

The largest therapeutic drug group, Opioid Analgesics (e.g., Hydrocodone-Acetaminophen, Tramadol), accounts for 27.0 percent of all California workers' compensation prescriptions. All of the opioids are listed as Non-Preferred drugs, and with the exception of very limited first-fill prescriptions, would be subject to prospective utilization review. Anti-Inflammatory Analgesics (e.g., Ibuprofen, Naproxen) and Ulcer Drugs (e.g., Omeprazole, Pantoprazole) are 96.5 and 99.3 percent Preferred drugs, respectively. Bulk Chemicals, which are the raw ingredients of compound drugs (e.g., Gabapentin, Ketamine), make up less than 3 percent of prescriptions but 11 percent of payments. Almost all of the Bulk Chemicals are Not Listed in the formulary, which would make them subject to prospective utilization review. Likewise, Hypnotics, Laxatives, Antihyperlipidemics, Beta Blockers and Antipsychotics are also Not Listed in the formulary, so they also would be subject to prospective utilization review.

The following exhibits display the top 20 drugs within each of the three formulary categories shown in Exhibit 1, and show each drug's share of prescriptions. The brand names represent the most common brand-name drugs within the study sample. Exhibit 3a summarizes the top 20 Preferred drugs, ranked by their volume as a percentage of all prescriptions in the sample.

Exhibit 3a: Top 20 Preferred Drugs–Percentage of Total Prescriptions Sorted by Volume

Active Drug Ingredient	Brand Name	Therapeutic Drug Group	Percent of Scripts
Ibuprofen	Advil	Anti-Inflammatory Analgesics	5.7%
Naproxen	Anaprox	Anti-Inflammatory Analgesics	5.6%
Omeprazole	Prilosec	Ulcer Drugs	4.7%
Nabumetone	Relafen	Anti-Inflammatory Analgesics	1.8%
Celecoxib	Celebrex	Anti-Inflammatory Analgesics	1.5%
Meloxicam	Mobic	Anti-Inflammatory Analgesics	1.1%
Pantoprazole	Protonix	Ulcer Drugs	1.0%
Diclofenac	Voltaren	Anti-Inflammatory Analgesics	1.0%
Etodolac	Lodine	Anti-Inflammatory Analgesics	0.6%
Flurbiprofen	Ansaid	Anti-Inflammatory Analgesics	0.5%
Ketoprofen	Oruvail	Anti-Inflammatory Analgesics	0.5%
Acetaminophen	Tylenol	Non-Narcotic Analgesics	0.3%
Esomeprazole	Nexium	Ulcer Drugs	0.3%
Ranitidine HCl	Zantac	Ulcer Drugs	0.3%
Sulfamethoxazole/Trimethoprim	Bactrim	Anti-Infective Agents - Misc.	0.2%
Lansoprazole	Prevacid	Ulcer Drugs	0.2%
Dexlansoprazole	Dexilant	Ulcer Drugs	0.2%
Amoxicillin/Clavulanate P	Augmentin	Penicillins	0.1%
Albuterol Sulfate	Proair	Antiasthmatic and Bronchodilator	0.1%
Famotidine	Pepcid	Ulcer Drugs	0.1%
Subtotal			**25.9%**
All Other			**0.7%**
Total (Preferred)			**26.6%**

Together, these 20 drugs accounted for 25.9 percent of all prescription drugs in the sample.

These 20 drugs represented the majority of all prescriptions for the formulary's Preferred drugs. All other Preferred drugs represented 0.7 percent of the prescriptions in the sample.

Exhibit 3b summarizes the top 20 Non-Preferred drugs, ranked by their volume as a percentage of all prescriptions in the sample.

Exhibit 3b: Top 20 Non-Preferred Drugs–Percentage of Total Prescriptions Sorted by Volume

Active Drug Ingredient	Brand Name	Therapeutic Drug Group	Percent of Scripts
Hydrocodone/Acetaminophen	Norco, Vicodin	Opioid Analgesics	14.4%
Tramadol HCl	Ultram	Opioid Analgesics	4.7%
Cyclobenzaprine HCl	Amrix	Musculoskeletal Therapy Agents	4.1%
Gabapentin	Neurontin	Anticonvulsants	3.8%
Oxycodone/Acetaminophen	Endocet, Percocet	Opioid Analgesics	1.6%
Duloxetine HCl	Cymbalta	Antidepressants	1.5%
Oxycodone HCl	Oxycontin	Opioid Analgesics	1.4%
Pregabalin	Lyrica	Anticonvulsants	1.3%
Carisoprodol	Soma	Musculoskeletal Therapy Agents	1.3%
Lidocaine	Lidoderm	Dermatologicals	1.3%
Tizanidine HCl	Zanaflex	Musculoskeletal Therapy Agents	1.3%
Tramadol HCl/AC	Ultracet	Analgesics - Opioid	1.2%
Orphenadrine Citrate	Norflex	Musculoskeletal Therapy Agents	1.0%
Diclofenac Sodium	Voltaren	Dermatologicals	0.8%
Codeine/Acetaminophen	Tylenol/Codeine	Opioid Analgesics	0.8%
Morphine Sulfate	Kadian	Analgesics - Opioid	0.7%
Trazodone HCl	Desyrel, Oleptro	Antidepressants	0.6%
Methocarbamol	Robaxin	Musculoskeletal Therapy Agents	0.6%
Bupropion HCl	Wellbutrin	Antidepressants	0.6%
Menthol	Polar Frost	Dermatologicals	0.6%
Subtotal			**43.8%**
All Other			**13.2%**
Total (Non-Preferred)			**57.0%**

Together, the top 20 Non-Preferred drugs accounted for 43.8 percent of the prescription drugs in the sample.

These 20 drugs represented three-fourths of all prescriptions for Non-Preferred drugs. All other Non-Preferred drugs accounted for 13.2 percent of the prescriptions in the sample.

Exhibit 3c summarizes the top 20 drugs that are Not Listed in the formulary, ranked by their volume as a percentage of all prescriptions in the sample.

Exhibit 3c: Top 20 Not Listed in MTUS Drugs–Percentage of Total Prescriptions Sorted by Volume

Active Drug Ingredient	Brand Name	Therapeutic Drug Group	Percent of Scripts
Zolpidem Tartrate	Ambien	Hypnotics/Sedatives/Sleep Disorder	1.5%
Alprazolam	Xanax	Antianxiety Agents	0.7%
Docusate Sodium	Promolaxin	Laxatives	0.4%
Gabapentin (Bulk)	Fanatrex Fusepaq	Chemicals	0.4%
Eszopiclone	Lunesta	Hypnotics/Sedatives/Sleep Disorder	0.4%
Cyclobenzaprine HCl (Bulk)	N/A	Chemicals	0.4%
Lisinopril	Prinivil	Antihypertensives	0.3%
Ondansetron	Zofran	Antiemetics	0.3%
Temazepam	Restoril	Hypnotics/Sedatives/Sleep Disorder	0.3%
Tramadol HCl (Bulk)	Synapryn Fusepaq	Chemicals	0.3%
Atorvastatin Calcium	Lipitor	Antihyperlipidemics	0.3%
Triamcinolone Acetonide	Kenalog	Corticosteroids	0.2%
Quetiapine Fumarate	Seroquel	Antipsychotics/Antimanic Agents	0.2%
Buspirone HCl	BuSpar	Antianxiety Agents	0.2%
Dietary Management Product	Theramine, Sentra	Dietary Management Products	0.2%
Metoprolol Succinate	Toprol	Beta Blockers	0.2%
Tetanus-Diphtheria-AP	Adacel	Toxoids	0.2%
Mirtazapine	Remeron	Antidepressants	0.2%
Clopidogrel Bisulfate	Plavix	Hematological Agents - Misc.	0.2%
Polyethylene Glycol	Miralax	Laxatives	0.2%
Subtotal			**7.1%**
All Other			**9.3%**
Total (Not Listed in MTUS)			**16.4%**

Together, these 20 drugs accounted for 7.1 percent of all prescription drugs in the sample.

These 20 drugs represented less than half of all prescriptions for Not Listed drugs. All other Not Listed drugs represented 9.3 percent of the prescriptions in the sample.

First-Fill Provisions

The proposed formulary identifies seven drugs that would qualify for the first-fill policy. Exhibit 4 shows that these seven drugs represented 24.5 percent of all California workers' compensation prescriptions and 13.9 percent of all payments when dispensed at any point within the course of treatment. When dispensed within the first seven days following the date of injury, these drugs represent 4.7 percent of all prescriptions. The MTUS drug list calls for all first- fill drugs to be limited to a 4-day supply. Data limitations prevent an estimate of the current average days fill for the 4.7 percent of such dispensed drugs.

Exhibit 4: First-Fill Drugs—Percentage of Total Prescriptions

Active Drug Ingredient	All Scripts	First Fill Scripts
Hydrocodone/Acetaminophen	14.4%	3.9%
Tramadol HCl	4.7%	4.6%
Oxycodone/Acetaminophen	1.6%	2.1%
Tizanidine HCl	1.3%	3.2%
Tramadol HCl/AC	1.2%	22.9%
Morphine Sulfate	0.7%	0.3%
Baclofen	0.5%	3.1%
Total	**24.5%**	**4.7%**

Discussion

AB 1124 provides the California workers' compensation system with a unique opportunity to improve quality of care, reduce utilization review friction costs, and lower the cost of pharmaceuticals. Given the high degree of variability in the drugs that are selected for the treatment of California injured workers, a formulary could improve the quality of care by focusing on proven medication therapies and requiring proof of efficacy and cost effectiveness for Non-Preferred and Not Listed prescriptions consistent with the evidence-based medicine standards of care outlined in the MTUS.

The proposed formulary provides a mechanism for reducing pharmaceutical dispute resolution expenses. Utilization review (UR) and independent medical review (IMR) have proven to be essential in objectively managing the quality, utilization, and cost of prescription drugs in California workers' compensation. CWCI's analysis of 2015 IMR outcomes found that 43 percent of UR decisions and 49 percent of IMR decisions were in response to requests for prescription drugs.[9] Under the proposed formulary, 26.7 percent of all currently prescribed drugs would be

[9] David, R. "Independent Medical Review Decisions: January through December 2015." CWCI Spotlight Report, Feb 2016.

classified as "Preferred," making them exempt from prospective UR as long as the prescription remains consistent with the MTUS. This would fast track a significant proportion of drugs to injured workers. The remaining Non-Preferred and Not Listed drugs (primarily opioids and core ingredients of compound drugs) are currently the most targeted drugs in utilization review and IMR, and for good reason. Mortality rates associated with the ongoing opioid epidemic are front page news. Hayes' 2016 study on the recent modest declines in opioid use shows that additional progress is possible.[10] The additional formulary controls on first-fill drugs and physician dispensing, and strict adherence to the MTUS should help sustain and augment the declining trend in unnecessary and costly opioid use and help contain the controversial use of compound drugs which account for more than 11 percent of pharmacy disputes.[11]

The current draft of the formulary also includes provisions to encourage further use of generic drugs where appropriate. Generic substitution provisions are not new to California workers' compensation,[12] and prior CWCI research has shown that when such a substitution is available, it occurs more than 94 percent of the time. Yet even though brand drugs constitute less than 10 percent of all opioids currently dispensed, the cost of these drugs is significant. For example, brand opioids account for 41 percent of all opioid costs in the system, and their average price per prescription has increased by 226 percent between 2005 and 2014.[13]

The MTUS formulary is not based at the National Drug Code (NDC) level. NDCs are unique 11-digit product codes assigned to all drugs in the United States. NDC-based formularies have the added ability to further segment drug lists by reimbursement levels. The California workers' compensation pharmacy fee schedule is based on the Medi-Cal fee schedule's use of the Federal Upper Limit (FUL), and in some cases, the Average Wholesale Price (AWP). Without eliminating high-cost options for therapeutic equivalent drugs, the proposed formulary leaves intact the high degree of price variability found across drug manufacturers for many commonly prescribed drugs. Exhibit 5 shows the unit price variation for six high-volume opioids currently dispensed and reimbursed in California workers' compensation.

Exhibit 5: Examples of Unit Price Variation—Opioid Analgesics

Active Drug Ingredient	Federal Upper Limit			Average Wholesale Price		
	Average	Minimum	Maximum	Average	Minimum	Maximum
Tramadol HCl	$3.82	$0.03	$16.49	$5.11	$0.09	$19.87
Oxycodone HCl	$4.86	$0.11	$153.38	$6.79	$0.28	$184.80
Oxycodone/Acetaminophen	$0.33	$0.10	$2.29	$3.13	$0.12	$18.38
Morphine Sulfate	$12.22	$0.07	$91.78	$15.95	$0.08	$108.41
Hydrocodone/Acetaminophen	$0.78	$0.13	$1.67	$3.34	$1.98	$9.60
Tramadol/Acetaminophen	$0.20	$0.20	$0.20	$3.16	$3.01	$3.31

[10] Hayes, S., Swedlow, A. Trends in the Use of Opioids in California Workers' Comp. CWCI Research Note, May 2016.
[11] Swedlow, A., Auen, E., Current Trends in Compound Drug Utilization & Cost in Workers' Comp, CWCI, Feb 2013.
[12] Labor Code section 4600.1.
[13] Hayes, S., Swedlow, A. Trends in the Use of Opioids in California Workers' Comp. CWCI Research Note, May 2016.

The 2014 CWCI formulary study and the 2016 RAND report both commented on the value of NDC-level price variation controls. Such a modification of the MTUS formulary drug list would not only reduce price variability, but would limit reimbursement for new drug formulations that can circumvent utilization and price controls.[14] Price controls in the California system have a proven track record of achieving their objectives. In 2007, the DWC closed a loophole in the adverse reimbursement mechanism for physician-dispensed repackaged drugs.[15] Prior to the regulatory change that normalized the price of repackaged drugs to the same price as those dispensed by a pharmacy, more than 55 percent of all drugs were physician-dispensed repackaged drugs. Shortly after implementation, the percentage of such drugs fell to less than 1 percent.[16] There is little public policy justification for paying a multiple, often 2 to 200 times or more, for a virtually identical lower cost equivalent.

Based on the preliminary analysis summarized in this report, the proposed formulary represents a significant step forward in achieving the legislative intent of AB 1124. In a follow-up report, the authors will provide a more in-depth analysis of the potential system-wide impact of the proposed formulary on UR and IMR expenses by comparing the specific drugs currently subject to UR and IMR, as well as dispute resolution outcomes, against the MTUS drug list.

[14] Wang, D., Thumula, V., Liu, T. Physician Dispensing of Higher-Priced New Drug Strengths and Formulations, Workers Compensation Research Institute, April 2016.
[15] In February 2007 the California Division of Workers' Compensation adopted revisions to the pharmacy fee schedule which, as of March 2007, largely eliminated the differential pricing between physician-dispensed repackaged drugs and pharmacy-dispensed drugs.
[16] Swedlow, A., Ireland, J. Claims Monitoring Report, CWCI, July 2014.

Glossary of Terms

Medical Treatment Utilization Schedule (MTUS) Drug Formulary List: The draft regulations and the Preferred Drug List include 257 distinct drugs along with general terms of use including:

Active Ingredient: The Preferred drug list contains the names of 257 active ingredients and does not differentiate between variations in dosage strength or formulation (e.g., tablet or cream).

Preferred /Non-Preferred/Not Listed: Each drug on the list is classified as either Preferred or Non-Preferred.

- Preferred drugs may be prescribed/dispensed without seeking authorization through Prospective Review if prescribed in accordance with the MTUS Guidelines.

- Non-Preferred drugs require authorization through Prospective Review prior to prescribing or dispensing the drug.

- Not Listed drugs are medications that are currently dispensed in the California workers' compensation system that are not listed in the formulary as Preferred or Non-Preferred.[17]

Generic May Be Available: The formulary seeks to maximize the use of generic drugs which are therapeutically equivalent to sole source (brand) drugs and typically manufactured by multiple sources at lower prices. Prescribing and dispensing brand-name Preferred drugs without generic substitution when an equivalent generic exists requires documentation of medical necessity and authorization through Prospective Review. If authorization is not obtained prior to dispensing and it is determined that the generic drug but not the brand drug is medically necessary, payment may be made at the fee scheduled amount for the lowest priced generic equivalent drug.

First Fill: "First Fill" is a drug prescription issued or drug dispensed at the initial visit following a workplace injury, where the visit occurs within 7 days of the date of injury. The draft formulary list limits the First Fill to a 4-day supply for specified drugs.

Drug Class: Drug class is a set of drugs that share a similar chemical structure and/or mechanism of action.

Reference in Guidelines: Each drug ingredient refers the user to the specific clinical topic(s) of the MTUS.

[17] The ACOEM/MTUS drug list only addresses preferred and non-preferred drug options discussed in the ACOEM medical treatment guidelines.

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California Workers' Compensation Institute

The California Workers' Compensation Institute (CWCI), incorporated in 1964, is a private, nonprofit organization of insurers and self-insured employers conducting and communicating research and analyses to improve the California workers' compensation system. Institute members include insurers that collectively write more than 70 percent of California workers' compensation direct written premium, as well as many of the largest public and private self-insured employers in the state. Additional information about CWCI research and activities is available on the Institute's website (www.cwci.org).

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