MedStar Health

# Medical Letter

For [redacted]



[redacted] MD, PhD

3-24-2023

MedStar Health

[redacted]

March 24, 2023

Honorable Judge Janis Sammartino,

Re: Incarceration of [redacted] III, DOB: 02/14/1972

I am writing this letter on behalf of my patient, [redacted]. I became [redacted] primary care physician on 10/21/2022 after his previous doctor retired. I have had the opportunity to both review his medical records and personally examine him.

[redacted] shared that he is facing incarceration. As an individual with pulmonary sarcoidosis and rheumatoid arthritis, both chronic, incurable, autoimmune diseases, he is being treated with methotrexate and prednisone. These medications decrease his body's immune response, which helps to reduce the severity of his symptoms. Unfortunately, it also means he is less able to fight off infectious illnesses, like COVID-19, influenza, and respiratory syncytial virus. As with many BOP institutions, the inmate population at each FCC Butner institution exceeds the institution's rated inmate capacity. Butner Low-Security Federal Correctional Institution (LSCI) inmates have beds in unenclosed cubicles in dormitory-style housing units. This significantly inhibited Butner's ability to socially distance inmates and, therefore, minimize the spread of COVID-19. These conditions contributed, in part, to over 1,000 inmates in these facilities contracting COVID-19 (Department of Justice, 2021). Placing Mr. Parks in a congregate living situation would put him at a very high risk of contracting an infectious respiratory disease, resulting in death.

[redacted] complies with all his medical appointments and treatment plans recommended by his physicians. He has received all available vaccines to help protect him against respiratory illness. Both the Coronavirus and influenza are

capable of rapidly forming new variants. Thus, while vaccines help decrease the likelihood of infection, they are not fully protective. In my work, I have recently seen a higher volume than usual of viral respiratory diseases. I do not doubt that this trend is similar in the prison community.

[redacted] has been assigned to FCC Butner Low; this institution infection prevention procedure or modification to operations is currently set at level 1. Therefore, changes are not necessary. Per the BOP Modified Operations Plan & Matrix (Enclosure A), Level 1 specifies: masks are recommended but not required for inmates at care levels 1 thru 3, both indoor and outdoor; social distancing is not necessary for all locations besides health care units; and staff, visitors and volunteers only have to self-monitor and report symptoms of Covid-19. According to DOJ, Pandemic Response, 53% of Butner staff were advised to continue reporting to work unless they experience symptoms (Department of Justice, 2021). Asymptomatic staff poses a very high risk of unknowingly transmitting a respiratory illness to Mr. Parks.

According to the Department of Justice Capstone Review of the Federal Bureau of Prison's Response to the Coronavirus Disease 2019 Pandemic (Reference 2), states the BOP plans to prioritize projects targeting the efficiency of heating, ventilation, and air conditioning systems, as these systems may affect the spread of COVD-19. Placing [redacted] in a BOP institution with insufficient air filtration system capable of removing respiratory virus particles puts Mr. Parks in an extremely dangerous environment as it would likely result in him contracting at least one virus during his sentence.

Last year, the Department of Justice Inspector General audited FCC Butner and two other institutions (Department of Justice, 2022). It was determined that the BOP did not have a formal plan to ensure the timeliness of the healthcare inmates received. It was noted that the BOP faced challenges in transporting inmates to off-site appointments, resulting in a frequent need to reschedule appointments that could delay an inmate's healthcare. Due to the variety of inmate medical needs, not all healthcare treatments can be provided within a facility. BOP medical staff described challenges that can add to the time inmates wait for treatment outside the facility, including limited staff to escort. To stabilize Mr. [redacted] medically, he must access regularly scheduled specialty care visits, routine visits with first [redacted] and now myself, to coordinate his care and address any urgent medical needs, uninterrupted access to his currently prescribed

medications and access to distilled water and cleaning supplies required to use his sleep apnea machine. Should any of these be unavailable to [redacted], he faces dire consequences, including death.

Due to the Prison's limited medication formulary (Federal BOP Health Services, Part 1 & 2, 2022), the most concerning is the assertion that [redacted] could not continue his methotrexate beyond fourteen (14) days. All new and renewal prescriptions require consultation with an appropriate specialist based on the disease state being treated; [redacted] could be waiting months for his consult. [redacted] has sudden flare-ups with his sarcoidosis (since Dec 2005) and is currently self-medicating when needed. It would be impossible for [redacted] to have quick access and the ability to take prednisone as he deems necessary. Not having the medication readily available could be life-threatening, he would be susceptible to permanent scarring of the lungs, difficulty breathing, pulmonary hypertension, kidney failure, muscle weakness or even cardiac arrest. Please see (enclosure B) for additional notes regarding [redacted] medication.

I am enclosing a DOJ BOP inmate death news release (Enclosure 3) of an inmate who also had long-term, pre-existing medical conditions which, the CDC lists as risk factors for developing more severe COVID-19, as [redacted]. I highly encourage you to consider the extenuating circumstances of his chronic autoimmune disorders and the detrimental impact conjugate incarceration would have on Mr. [redacted] as you determine his sentence. He may not come home if incarcerated.

Sincerely,

[redacted] MD, PhD
Family Medicine

MedStar Medical Group – [redacted]

[redacted]

[redacted]

## REFERENCES


1. Department of Justice Office of the Inspector General (2021, January). *Remote Inspection of Federal Correctional Complex Butner,* pgs. iii, 1, & 27. https://oig.justice.gov/sites/default/files/reports/21-031.pdf

2. Department of Justice Office of the Inspector General (2023, March). *Capstone Review of the Federal Bureau of Prisons' Response to the Coronavirus Disease 2019 Pandemic,* p. 30. https://oig.justice.gov/sites/default/files/reports/23-054.pdf

3. Department of Justice Office of the Inspector General (2022, March). *Audit of the Federal Bureau of Prisons Comprehensive Medical Services Contracts Awarded to the University of Massachusetts Medical School,* pgs. 12-15. https://oig.justice.gov/sites/default/files/reports/22-052.pdf

4. Department of Justice Federal Bureau of Prisons (2022, May). *National Formulary Part 1.* https://www.bop.gov/resources/pdfs/2022_winter_formulary_part_1.pdf

5. Department of Justice Federal Bureau of Prisons (2022, May). *National Formulary Part 2.* https://www.bop.gov/resources/pdfs/2022_winter_formulary_part_2.pdf

DEPARTMENT OF JUSTICE | OFFICE OF THE INSPECTOR GENERAL

**PANDEMIC RESPONSE REPORT**

**21-031**

**JANUARY 2021**

# Remote Inspection of Federal Correctional Complex Butner

EVALUATION AND INSPECTIONS DIVISION

## COVID-19 at FCC Butner

At the time of our inspection, FCC Butner housed approximately 4,000 medium, low, minimum, and administrative security male inmates in four institutions with a total of five separate facilities spanning both Granville and Durham Counties, North Carolina: two medium security Federal Correctional Institutions (FCI I and FCI II); a Low Security Federal Correctional Institution (LSCI); a minimum security Satellite Camp (Camp), which is adjacent to and part of FCI I; and an administrative security Federal Medical Center (FMC).[5] Approximately 1,200 FCC Butner staff members provide daily correctional, medical, and other services at the complex.[6] Butner's unique inmate population includes elderly inmates receiving nursing care; inmates with serious or chronic medical problems that require specialized treatment, including radiation, chemotherapy, dialysis, and physical therapy; inmates needing orthopedic and other minor surgeries that can be performed at the FMC; and inmates receiving mental and behavioral health treatment and services, including inmates undergoing court-ordered forensic evaluations, incompetent or sexually dangerous inmates who are civilly committed by court order, and inmates participating in residential psychology programs such as the Mental Health Step Down Unit Program.[7]

Although FCC Butner was receiving fewer inmates than it normally would because of the BOP's restrictions on inmate transfers due to COVID-19, during our inspection the complex was continuing to receive new inmates as a result of court orders, sentencings, and medically necessary transfers. During the suspension of most internal inmate movements between March 13 and July 15, 2020, the complex received 36 inmates transferred from other BOP institutions to receive medical or mental healthcare.

As of July 25, 1,020 FCC Butner inmates, including 698 LSCI inmates, had confirmed COVID-19 cases. Additionally, 25 inmates had died of COVID-19 as of that date. Also, as of July 25, 70 staff members had confirmed COVID-19 cases and 1 had died. As can be seen in the charts below, the COVID-19 outbreak was most serious at Butner between June and mid-July and began to diminish in intensity thereafter; however, Butner began seeing new cases in late October and November in the FMC, and in January 2021 at the FCI II. As of January 17, 2021, according to BOP data, 226 inmates had active COVID-19 cases and 2 additional inmates had died as a result of COVID-19,

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[5] As with many BOP institutions, the inmate population at each FCC Butner institution exceeds the institution's rated inmate capacity.

[6] BOP officials assign each inmate a care level based on the inmate's individual medical needs. Care levels range from Care Level 1 for the healthiest inmates to Care Level 4 for inmates with the most serious medical conditions. The BOP designates inmates to appropriate institutions based on several factors, including inmates' healthcare needs. Each BOP institution is classified with a care level based in part on available community healthcare resources. FMC Butner, as a Medical Care Level 4 institution, houses and cares for inmates with the most serious medical conditions. FCI I (including the Camp), FCI II, and the LSCI are all Medical Care Level 3 institutions.

[7] The Mental Health Step Down Unit Program is a residential treatment program for inmates with serious mental illnesses who cannot function in a general population prison setting. The program's goal is to maximize the inmates' ability to function and minimize relapse and the need for inpatient hospitalization.

## INSPECTION RESULTS

### Social Distancing and Physical Layout Challenges

We found that while FCC Butner's FMC, LSCI, FCI I, and FCI II made efforts to implement inmate social distancing and limit group gatherings in accordance with BOP guidance, its Camp did not fully or promptly implement all restrictions on inmate movements.[8] We also found that the open, dormitory-style layouts and communal bathrooms of the housing units in the LSCI, FCI I, and the Camp, which as of July 25, 2020, collectively housed nearly half (1,894 of 4,168) of FCC Butner's inmate population, significantly inhibited Butner's ability to socially distance inmates and therefore minimize the spread of COVID-19.[9] We believe that these conditions contributed, in part, to over 1,000 inmates in these three facilities contracting COVID-19. Conversely, at the FMC and FCI II, where there were 11 confirmed inmate COVID-19 cases as of July 25, most inmates are confined in locked cells with solid doors.[10]

On March 13, the BOP advised institutions to suspend legal and social visitation and to maximize social distancing as much as practicable, which all Butner facilities implemented that day.[11] Specifically, the Camp adjusted food service so that inmates would collect their own carry-out meals from the dining hall and then return to their housing units to eat. However, we learned that the Camp did not take actions consistent with subsequent March 31 BOP guidance to further restrict inmate movements until it locked down its housing units on April 16, which was 1 day after the first Camp inmate tested positive for COVID-19 (on April 15) and 7 days after the first staff member tested positive (on April 9).[12] According to the Camp Warden's testimony and other

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[8] Social distancing, also called "physical distancing," means keeping at least 6 feet between people and avoiding group gatherings. In a correctional setting, the CDC recommended implementing a host of strategies to increase the physical space between inmates (ideally 6 feet between all individuals, regardless of symptoms), noting that not all strategies will be feasible in all facilities and that strategies will need to be tailored to individual spaces within the facility and the needs of the population and staff. See CDC, "Interim Guidance." Throughout this report, we use the term "social distancing," rather than "physical distancing," to correspond to the terminology of CDC, DOJ, and BOP guidelines.

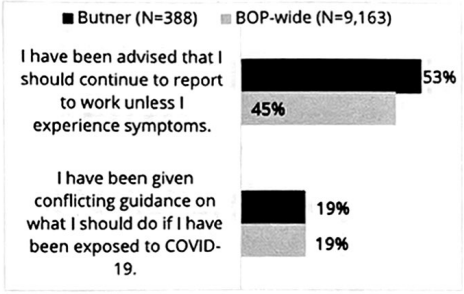
[9] LSCI and Camp inmates have beds in unenclosed cubicles in dormitory-style housing units. Although some FCI I inmates share rooms with solid doors, others have beds in open-bay, communal areas. Further, nearly all inmates at these facilities use communal bathrooms, which requires inmates to regularly move through housing units.

[10] The FMC's work detail inmates are housed in a dormitory-style housing unit.

[11] BOP, memoranda for All Chief Executive Officers, Coronavirus (COVID-19) Phase Two Action Plan, March 13, 2020, 1, and Coronavirus (COVID-19) Phase Nine Action Plan, August 5, 2020, 1–3. On March 13, the BOP directed institutions to suspend all social visits and legal visits for 30 days, which was subsequently extended until October 31 and, on November 1, until further notice. The BOP guidance permitted institutions to accommodate case-by-case requests for legal visits. Further, the guidance stated that prisons should offer video conferencing as an alternative to in-person legal visits. BOP, memoranda for All Chief Executive Officers, March 13, 2020, 1; August 5, 2020, 1–3; Coronavirus (COVID-19) Extension to Phase Nine Action Plan, November 1, 2020.

[12] BOP, memorandum for All Chief Executive Officers, Coronavirus (COVID-19) Phase Five Action Plan, March 31, 2020. The BOP enacted a "14-day nationwide action to minimize movement to decrease the spread" of COVID-19 in its Phase (Cont'd.)

**Which of the following statements best describes the current guidance you have received from facility leadership about what you should do if you have been exposed to COVID-19? (Top 2 Responses)**




**How strongly do you agree with the following statements about the adequacy of the guidance you have received about what you should do if you have been exposed to COVID-19? (All Responses)**

*Respondents rated each item on a 5-point scale, with "strongly disagree" worth 1 point and "strongly agree" worth 5 points. "Don't know" responses are excluded.*

| | Butner Rating | BOP-wide Rating |
|---|---|---|
| The guidance was timely. | 3.06 | 3.18 |
| The guidance was clear. | 2.89 | 2.97 |
| The guidance was comprehensive. | 2.97 | 3.03 |

**How strongly do you agree with the following statements about the adequacy of the practices your institution is taking to mitigate the risk of spreading COVID-19? (Top 3 and Bottom 3 Responses)**

| *Respondents rated each item on a 5-point scale, with "strongly disagree" worth 1 point and "strongly agree" worth 5 points. "Don't know" responses are excluded.* | Butner Rating (N=378) | BOP-wide Rating (N=8,978) |
|---|---|---|
| **Three Practices Rated Highest:** | | |
| Staff are provided a sufficient supply of soap. | 4.05 | 3.90 |
| Staff are given sufficient information about COVID-19 symptoms and preventive actions (hand washing, wearing masks). | 4.04 | 4.09 |
| Inmates have ample opportunity to shower at least three times a week. | 3.87 | 4.27 |
| **Three Practices Rated Lowest:** | | |
| Shared staff equipment such as radios and keys is regularly cleaned and sanitized. | 3.03 | 3.15 |
| Inmates are provided a sufficient supply of hand sanitizer where sinks are not available. | 2.92 | 3.07 |
| Staff are provided a sufficient supply of masks. | 2.88 | 3.13 |


# Capstone Review of the Federal Bureau of Prisons' Response to the Coronavirus Disease 2019 Pandemic

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EVALUATION AND INSPECTIONS DIVISION

23-054

MARCH 2023

not, and deviations from established guidance (opportunities for improvement)." However, in a July 2021 report on the BOP's COVID-19 response, the U.S. Government Accountability Office (GAO) recommended that the BOP take additional steps to ensure that lessons learned and best practices are captured, particularly those discussed among BOP officials during their regular information sharing teleconferences.[48] The GAO further recommended that the BOP develop and implement an approach for ensuring that its facilities are applying the best practices, as appropriate.

The BOP has reported that it considered potential permanent changes to facility infrastructure to help mitigate the risk of infection transmission inside its facilities. For example, Federal Correctional Institution (FCI) Terminal Island reported that it was considering placement of computers in the housing units instead of using a shared computer lab, which could help ensure access to the Trust Fund Limited Inmate Computer System (TRULINCS) inmate email system during extended modified operations while limiting cross-contamination among housing units.[49] The BOP should also look for opportunities to incorporate proactive infrastructure changes into its planned construction, modernization, and repair projects.[50] In its fiscal year 2022 budget submission, the BOP reported having 904 ongoing major and minor modernization and repair projects at its facilities. The BOP Facilities Management Branch Chief told us that the BOP plans to prioritize projects targeting the efficiency of heating, ventilation, and air conditioning systems, as these systems may affect the spread of COVID-19.[51]

***Conclusion***

Building on these steps already taken or in progress, we recommend that the BOP specifically look at the challenges related to the limitations of existing facility infrastructure and the methods that have been successful in mitigating those challenges. First, as described above, facilities have unique challenges based on their specific layouts, populations, and other circumstances. In addition to ensuring that best practices are shared such that similarly situated facilities can benefit from lessons learned during the pandemic, facility-specific measures and solutions should be captured and updated in individual facility pandemic plans. Updating these plans will ensure that future facility leadership will have access to information on what has worked well in their facility's context if they need to respond to a public health emergency in the future. The BOP reported that it has already made several updates to its pandemic contingency plans based

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[48] GAO, *BOP Could Further Enhance Its COVID-19 Response by Capturing and Incorporating Lessons Learned*, GAO-21-502 (July 2021), www.gao.gov/products/gao-21-502 (accessed July 11, 2022), 58.

[49] TRULINCS enables electronic messaging (email) between inmates and approved contacts in a monitored and secure manner. DOJ, OIG, *Remote Inspection of Federal Correctional Institution Terminal Island*, E&I Report 21-025 (January 2021), oig.justice.gov/reports/remote-inspection-federal-correctional-institution-terminal-island.

[50] Since 2017, the OIG has identified aging infrastructure at BOP facilities as an area of concern in its *Top Management and Performance Challenges* reports. The OIG is currently conducting an audit of the BOP's efforts to construct and maintain its institutions. See DOJ OIG, "Audit of the Federal Bureau of Prisons' Efforts to Maintain and Construct Institutions," oig.justice.gov/node/23304.

[51] The CDC states that the risk of spreading the virus that causes COVID-19 through ventilation systems is not yet clear. However, the CDC does recommend improvements to building ventilation as tools to use in conjunction with other measures, such as social distancing, hand hygiene, and vaccination, to help reduce risk of exposure to the virus. See CDC, "Ventilation in Buildings," updated June 2, 2021, www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html (accessed July 11, 2022).


# Audit of the Federal Bureau of Prisons Comprehensive Medical Services Contracts Awarded to the University of Massachusetts Medical School

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22-052

MARCH 2022

At FCI Ray Brook, we found that the delegated COR retired in October 2019 and a replacement COR had not been selected because the facility did not have a FAC-COR Level II certified staff member in the Health Services unit.

We also found that the COR at FMC Devens did not maintain the FAC-COR Level II certification after June 2019 because continuous learning requirements were not met by the COR. To maintain a FAC-COR Level II, CORs are required to complete 40 continuous learning points (CLP) hours every 2 years. FAC-COR certification is managed at the federal agency level and, as such, DOJ identifies the training courses that may be taken to satisfy the continuous learning requirement. We found that while the COR at FMC Devens had taken the required hours of training, some of the hours were not eligible to be used for continuous learning purposes according to DOJ's policy. We believe that the risk of poor contract administration increases when delegated staff fail to maintain their certifications.

We recommend that the BOP review and enhance its policies and procedures to ensure that those delegated to administer CMS contracts are appropriately certified, and that appropriate delegations are in place.

## Contract Performance

The CMS contracts we audited required UMass to establish a network of medical specialists to conduct on-site clinics inside facilities and provide inpatient and outpatient services in a community-based setting, such as at local physician's offices, hospitals, and other healthcare facilities. According to the contracts, UMass must conform to community standards in the delivery of healthcare, which includes providing care in a timely manner.[14] During our interviews, BOP officials told us that they did not identify any significant issues related to UMass's performance of contract requirements. However, we found areas where BOP can improve its oversight of contract performance requirements, including monitoring the timeliness and quality of inmate care, ensuring required specialty on-site clinics are provided, and managing and understanding the causes and effects of appointment cancellations on inmate care.

### Inpatient and Outpatient Services

For our audit, we visited FCC Butner, FMC Devens, and FCI Ray Brook and reviewed the contracts awarded to UMass to provide medical services at the facilities. The FMC at FCC Butner and FMC Devens are two of the BOP's six FMCs that are classified as Care Level IV facilities and house inmates with severe health problems and may require daily nursing care. BOP's Care Level IV facilities possess the bureau's most advanced clinical capabilities and resources.

Based on our review of BOP's monitoring records and interviews of BOP's contracting and medical staff, we determined that BOP was generally satisfied with the quality and quantity of services provided under all three contracts. While the healthcare provided to the inmates was continuously monitored throughout their medical evaluations, we found that the BOP did not have a formal process in place to ensure the timeliness of the healthcare inmates received. For the contracts we audited, we found that the BOP did not utilize any mechanisms to consistently review and evaluate UMass's performance of the contract requirements, including the quality and timeliness of healthcare. At the conclusion of our audit, BOP officials told us this is done using

[14] Community standard refers to the level and type of care that a reasonably competent and skilled health professional, with a similar background and in the same medical community, would have provided under the circumstances.

reports generated from the BOP's electronic medical records system and completion of the Quality Assurance Surveillance Plan.[15] However, during our audit, we were not provided evidence that these evaluations were completed for the contracts audited.

We also found that the BOP did not ensure UMass provided all the on-site clinics required by the contracts and it was therefore necessary for BOP to transport inmates outside facilities for treatment, resulting in avoidable security risks and additional expenses. Further, we found that the BOP faced challenges in transporting inmates to off-site appointments which resulted in a frequent need to reschedule appointments that could delay an inmate's healthcare. In addition, the BOP did not have systems in place to track and monitor the causes for rescheduling appointments, including whether the reason for a cancellation was a BOP issue or one that was out of its control, such as the physician cancelling the appointment. BOP also did not have a process in place to monitor how long an inmate waited to receive care after a cancelled appointment. Because the BOP did not have systems to measure or track any of these issues, we believe it is difficult for the BOP to determine whether inmates are receiving care within the required community standard.

Clinics provided by CMS contractors within BOP facilities are critical for BOP efforts to effectively and efficiently address the health care needs of its inmates. These clinics also help BOP manage security risks and cancellations by avoiding transporting inmates to community hospitals and doctors' offices. The CMS contracts we audited identified the clinics UMass was expected to provide according to medical specialty. For example, at both FCC Butner and FMC Devens, the contracts required UMass to provide clinics for specialties such as cardiology, optometry, vascular surgery, and infectious disease. The CMS contract at FCC Butner also required UMass to provide after-hour physicians to ensure inmates had around the clock medical care.

From our discussions with BOP and UMass staff and in reviewing documentation, we found that UMass did not always provide all the medical specialty clinics required by the contracts. Because of this, the BOP was required to transport inmates to off-site facilities for appointments in specialty areas for which there was no on-site clinic. Also, we found that even though some specialty areas were included in the contracts, BOP did not enforce the contract requirements to provide certain on-site clinics because the demand for the specialty area of care was not sufficient to support the clinic. BOP did not revise or modify the contract requirements in these situations because of the changing needs of its inmates at the facilities could change in the future. However, in other circumstances, we found that the BOP identified on-site clinics that were included in the contract requirements, but UMass was unable to provide physicians to conduct the clinics. For example, at FCC Butner, UMass did not continuously provide a vascular surgery physician for the required on-site clinic. From September to October 2019, 17 appointments were required to be scheduled off-site for this specialty even though the contract required an on-site clinic for vascular surgery. When appointments are completed off-site, there is an additional security risk and other appointments cannot be scheduled due to limited BOP resources for off-site appointments. Additionally, we found that when required on-site clinics were not provided, the BOP did not take any further action to promote contract compliance by ensuring that UMass staff the clinics, except to discuss the status of the vacant clinics at the monthly contractor meetings.

We reviewed the issue of vacant clinics with UMass officials who told us that they are sometimes unable to fill certain clinics because it is difficult to recruit qualified professionals willing to treat inmates inside BOP facilities. UMass officials also told us that the BOP includes in its solicitations for CMS contracts certain clinics that are

[15] The Quality Assurance Surveillance Plan is required by FAR Part 46 and includes rating elements such as quality of goods/services, timeliness of deliveries/performance, business relations, and customer satisfaction.

never requested by the facility throughout the life of the contract. We reviewed the recent solicitation for a follow-on contract at FCI Ray Brook that required certain clinics even though these clinics had not been provided by UMass in the preceding 5 years covered by the existing contract. Although this solicitation was beyond the scope of our audit, the BOP stated that it included these on-site clinics in the solicitation in the event that inmate needs change at the facilities.

Due to the variety of inmate medical needs, not all healthcare treatments can be provided within a facility. The CMS contracts contemplate the need for inmates being seen outside the facility in cases where the level of inmate health care needed exceeds the medical care BOP can provide within the facility, or through available on-site clinics provided by UMass. In these circumstances, BOP is responsible for transporting these inmates to area hospitals and doctors' offices. While BOP officials told us they did not have any concerns regarding UMass's scheduling of appointments and the care inmates received outside the facility, they described for us some challenges that can add to the time inmates wait for treatment outside the facility. These challenges included limits on staff available to escort inmates and the limited number of trips leaving facilities on a single day. For example, FCC Butner and FMC Devens officials told us that many off-site appointments were rescheduled due to emergency medical trips out of the facility that required around the clock correctional staff coverage and limited how many other trips could be made out of the facility. UMass and BOP officials also told us that appointments are rescheduled for other unanticipated reasons, such as inmate refusal to attend the appointment, illness of the inmate, or rescheduling required by the medical provider.

UMass officials also told us that there was a significant amount of time spent by its staff cancelling and rescheduling inmate appointments. During our audit, we found that the BOP does not adequately track cancelled or rescheduled inmate appointments, and we were unable to determine what impact these cancellations and rescheduling had on the delivery of timely medical care to inmates. Due to the lack of reliable information, we also were unable to verify information provided by UMass regarding the number of cancelled or rescheduled appointments and the reasons why the appointments were cancelled or rescheduled. The Health Services staff at FCC Butner and FMC Devens told us that they believed most of the cancelled or rescheduled appointments were due to emergency medical trips that took precedence over scheduled, routine appointments, and this resulted in a lack of available BOP correctional officers and vehicles, but we did not identify documentation that supported this explanation.

While we agree the environment for scheduling and transporting inmates for treatment outside the facility is challenging, we found that the BOP does not have a process in place to track cancelled or rescheduled inmate appointments in order to determine wait times, identify causes of cancelling or rescheduling appointments, or demonstrate that UMass was rescheduling inmate appointments in a timely way following a cancellation.

At the conclusion of our audit, we discussed these issues with BOP officials and were told that inmates healthcare is consistently monitored, and the timeliness of outside appointments was determined by the referring physician using community standards. However, as discussed above, we were unable to determine from BOP records whether delays that resulted when appointments were cancelled and rescheduled impacted the delivery of inmate healthcare.

To improve compliance with contract terms related to inpatient and outpatient services, we recommend that BOP ensure that BOP staff delegated performance surveillance responsibilities complete required performance reporting tasks and maintain supporting documentation for the contractor's ratings. BOP should also provide

facility staff guidance and tools for the steps that can be taken when contract requirements are not fulfilled in a timely manner.

Additionally, BOP should implement a reliable, consistent process throughout all BOP facilities to monitor and analyze wait times for outside inmate appointments and the causes for cancelled or rescheduled appointments in order to ensure that inmates receive timely medical care.

## Comprehensive Medical Services Costs Billing Process

From our review of the billing process for medical costs at the three facilities, we identified areas for improvement, including ensuring billings for off-site medical services using Medicare rates are adequately reviewed, sufficient documentation is maintained for on-site providers, appropriate delegations for staff who approve billings for payment, and facilities have procedures in place to avoid the payment of interest.

### Off-site Medical Services Billings

Off-site physician services, medical procedures, and hospital services billed by UMass, as well as other CMS contractors, use Medicare-based rate structures that are often complex.[16] To address the risks associated with the significant amounts billed by contractors for CMS contracts, and the additional complexities created by the use of the rate structures, the BOP contracted with a third-party claims adjudication vendor to ensure the accuracy of claim information, verify that the BOP is not billed for duplicate claims, and verify the local benchmark Medicare rate structures used in the billings.

In 2017, the OIG issued a report that included a recommendation to the BOP to require CMS contractors to submit electronic claims, ensure those claims are properly analyzed and maintained by the BOP's adjudication vendor, and enforce existing contract language that requires the adjudication vendor to perform fraud analytics and report any indicators of fraud to the BOP. This recommendation was based on the determination that BOP medical care claims were processed primarily through paper based manual methods. In response to the OIG's recommendation, the BOP awarded a medical claims adjudication services contract, but, as of March 2020, the BOP had not begun using the adjudication vendor because of technology issues within the BOP.

During our audit, we found that the three facilities each processed its off-site medical services claims in a different manner. We found that FCC Butner utilized the third-party adjudication vendor until August 2019, but since that time its medical service claims were not processed through the adjudication vendor. In addition, from August 2019 to March 2020, UMass billed over $20 million for medical services provided to FCC Butner that were not reviewed through an adjudication process. Facility staff told us that the invoices were merely reviewed for mathematical accuracy and to ensure the inmate received the services billed. Based on the volume of medical services claims, we believe the BOP is at risk of overpaying for medical services incurred by the inmates at FCC Butner due to the adjudication vendor not being appropriately utilized and the complexities to review Medicare rates.

[16] The contracts in our audit utilize Medicare Part A or B Benchmark pricing for the specific locality with a premium applied.


Federal Bureau of Prisons
Health Services

# National Formulary

## Part I

Approved:

ELIZABETE STAHL

Digitally signed by ELIZABETE STAHL
Date: 2022.05.02 11:54:49 -04'00'

Dr. Elizabete Stahl, DO, Medical Director

# Summary of Formulary Changes Winter 2022 Meeting

*** The prescribing of medications against the restrictions, without an approved non-formulary request, is considered an unauthorized use of government funds. The procurement of non-formulary medications or the procurement of formulary medications used outside of formulary restrictions is considered an unauthorized procurement. The prescriber is responsible for justifying the non-formulary request. ***

The following is a summary of the major changes as a result of the Winter 2022 BOP Formulary meeting; please refer to the Winter 2022 National P&T minutes for additional information and detailed discussion regarding all of the changes. Revisions or changes from the previous year are highlighted in yellow throughout the document.

| Topic | Final Action |
|---|---|
| Amoxicillin/clavulanate (Augmentin®) oral | **ADD** inclusionary diagnostic criteria |
| Azithromycin | **UPDATE** inclusionary diagnostic criteria |
| Brexpiprazole (Rexulti®) oral | **ADD** Non-formulary Use Criteria |
| Budesonide, glycopyrrolate, and formoterol inhalation (Breztri® Aerosphere) | **DO NOT ADD**<br>**ADD** Non-formulary Use Criteria |
| Clopidogrel (Plavix®) oral | **RETAIN** |
| Coal tar shampoo, gel, solution (OTC) | **ADD** Non-formulary Use Criteria |
| Desiccated Thyroid Extract Oral Tablets (Armour Thyroid®, NP Thyroid®, Nature-Thyroid®, etc.) | **DO NOT ADD** advisory |
| Diltiazem injection | **DO NOT ADD** to the Urgent Care Cart and Kit Content List |
| Docusate Sodium Oral | **ADD** inclusionary diagnostic criteria<br>**DELETE** restriction |
| Emtricitabine/tenofovir alafenamide (Descovy®) | **ADD** inclusionary diagnostic criteria<br>**ADD** Non-formulary Use Criteria |
| Emtricitabine/tenofovir disoproxil (Truvada®) | **DELETE** restriction |
| Fluticasone furoate, umeclidinium, and vilanterol inhalation (Trelegy®) | **DO NOT ADD**<br>**ADD** Non-formulary Use Criteria |
| Glycopyrrolate/formoterol inhalation (Bevespi®) | **DO NOT ADD**<br>**ADD** Non-formulary Use Criteria |
| Hydrocortisone cream, ointment (OTC) | **ADD** Non-formulary Use Criteria |
| Infliximab (Remicade®) injection | **ADD** Non-formulary Use Criteria |
| Insulin (Concentrated) Injection | **DELETE** |
| Latanoprost (Xalatan®) ophthalmic solution | **DELETE** restriction |
| Levofloxacin (Levaquin®) Oral/Injection | **ADD** exclusionary diagnostic criteria |
| Lumateperone (Caplyta®) oral | **ADD** Non-formulary Use Criteria |
| Magnesium sulfate injection | **ADD** to the Urgent Care Cart and Kit Content List |
| Naloxone Nasal Spray (Narcan® Nasal Spray) | **DELETE** restriction (with contingency)<br>**UPDATE** to 365-day order duration |
| Norepinephrine injection | **DO NOT ADD** to the Urgent Care Cart and Kit Content List |
| Omeprazole/sodium bicarbonate (Zegerid®) oral | **DO NOT ADD** |
| Ondansetron injection | **RETAIN**<br>**DO NOT ADD** to the Urgent Care Cart and Kit Content List |
| Prasugrel (Effient®) oral | **ADD** Non-formulary Use Criteria |
| Ramelteon (Rozerem®) oral | **ADD** Non-formulary Use Criteria |
| Ticagrelor (Brilinta®) oral | **ADD** Non-formulary Use Criteria |
| Tiotropium/olodaterol inhalation (Stiolto®) | **ADD** with inclusionary diagnostic criteria<br>**ADD** Non-formulary Use Criteria |
| TNF-α inhibitors injection (class) | **UPDATE** Non-formulary Use Criteria |
| Umeclidinium/vilanterol inhalation (Anoro Ellipta®) | **DO NOT ADD**<br>**ADD** Non-formulary Use Criteria |

## Hydrocortisone cream, ointment (OTC)

1. Patient is indigent and has failed OTC Indigent Program alternatives (ex: Hydrocortisone 0.5% cream) and treatment is medically necessary. Orders are limited to 30 days in duration when approved on the basis of indigent status alone. If renewed, indigent status will be reassessed.
2. For Psoriasis: lesions interfere with function
3. For Psoriasis: Psoriasis affects >10% of BSA (refer patients to commissary for mild psoriasis) OR crucial body areas (hands, feet, face etc.)

## Hydroxyzine (Atarax®, Vistaril®) oral - See Antihistamines

## Icosapent ethyl (Vascepa®)

1. Failure to achieve therapeutic triglyceride level (<150 mg/dL) with maximally tolerated statin AND diabetes. ASCVD, or high risk for CV events (ASCVD risk >7.5%) OR
2. Severe hypertriglyceridemia (≥ 500 mg/dL)

## Immunomodulator TNF Inhibitors: adalimumab (Humira®), certolizumab (Cimzia®), etanercept (Enbrel®), golimumab (Simponi®), infliximab-abda (Renflexis®), infliximab-dyyb (Inflectra®)

1. Adalimumab is recommended agent before etanercept and golimumab due to better side effect profile and cost effectiveness.
2. Failure of an adequate trial of maximally dosed/tolerated methotrexate/prednisone or other formulary non-biologic DMARDs.
3. Intolerable side effects of methotrexate where a TNF agent may allow a decrease in methotrexate dose.
4. All new and renewal prescriptions require consultation with an appropriate specialist based on the disease state being treated (for example, dermatologist, gastroenterologist, or rheumatologist). Consult must be uploaded in BEMR.
5. Requests for patients with a TST > or = 5mm or positive IGRA (interferon gamma release assay) test must be accompanied by evidence of LTBI treatment completion (medication used with ingested dose counts). TST or IGRA must be repeated yearly.
6. Initial requests must include HBV/HCV serology for prior evidence of hepatitis infection.
7. For chronic plaque psoriasis:
    a. Request includes documented percent of affected BSA % AND
    b. Patient has failed of an adequate trial of a clinically indicated formulary non-biologic agent AND
    c. ≥ 10% BSA is affected (Severe CPP) OR
    d. At least ≥ 5% of BSA (Moderate CPP) AND crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
    e. NFR renewals must include documentation of improved symptoms (% BSA impacted)
    f. Patients with mild CPP may be managed with formulary topical treatments.

## Infliximab (Remicade®)

1. Infliximab abda (Renflexis®) is the preferred infliximab agent over both infliximab (Remicade®) and infliximab dyyb (Inflectra®).

## Infliximab abda (Renflexis®), infliximab dyyb (Inflectra®)– See Immunomodulator TNF Inhibitors

## Insomnia medications: (Ambien®, Lunesta®, Sonata®)

Insomnia is typically a symptom, and not a disease state, and thus the clinical focus should be on identifying and treating the underlying cause (i.e., depression, anxiety, psychosis, poor sleep hygiene, and chronic medical conditions such as diabetes). The long term use of antidepressants or antihistamines for complaints of poor sleep in the absence of another Axis I diagnosis is not appropriate.

## Long-Acting Beta-Agonist/Long-Acting Muscarinic-Antagonist/Inhaled Corticosteroid (LABA/LAMA/ICS): budesonide, glycopyrrolate, and formoterol (Breztri® Aerosphere), fluticasone furoate, umeclidinium, and vilanterol (Trelegy®)

1. COPD patient with a history of exacerbations requiring hospitalization or ≥ 2 moderate exacerbations/year and a blood eosinophil count of > 300 cells/µL. (Attach labs)
2. Asthma: patient failed high dose ICS/LABA combination. *Evidence to the benefits of triple therapy is limited in asthma – if asthma control not improved in 90-day trial, add-on should be discontinued
3. Non-formulary requests for LABA/LAMA/LABA that meet criteria will be approved for most cost-effective agent or combination of agents.

## Loperamide (Immodium®)

1. Patient is indigent, treatment is medically necessary, AND has failed OTC Indigent program alternatives. Orders are limited to 30 days in duration.

## Loratadine (Claritin®) – See Antihistamines

## Lorazepam long-term use - See Benzodiazepines

## Loteprednol etabonate (Lotemax®, Alrex®)

After use of formulary ophthalmic steroid for greater than 28 days.

## Lumateperone (Caplyta®)

1. Medication is being utilized to treat patients who carry diagnosis in BEMR for a schizophrenia spectrum disorder
2. Failure of 3 or more formulary oral antipsychotic treatment trials due to significant adverse reactions that are unable to be managed by dose reductions of the causative agent
3. Details related to prior antipsychotic treatment failures are documented in the above comments to include medications, doses, durations, compliance, and (as applicable) adverse drug reactions (ADRs).

## Lurasidone (Latuda®)

1. Request is in accordance with the Schizophrenia and/or Bipolar Clinical Guidance documents or has justification as to why prescribing is different from recommendations in clinical guidance.
2. If weight gain is a concern, patient must have documented failure with or contraindications to formulary weight neutral options (aripiprazole and ziprasidone). Dose and duration of failed treatments as validated via eMAR. Must specify why weight gain is concerning in this patient (e.g., comorbid medical conditions, notably elevated BMI, etc.)

## Magnesium/aluminum/simethicone containing products (Maalox®/Mylanta®/Gaviscon®, Milk of Magnesia®, etc.)

1. Patient is indigent, treatment is medically necessary, AND has failed OTC Indigent program alternatives. Orders are limited to 30 days in duration.

## Maraviroc (Selzentry®) – See HIV Medication/Treatment

## Metaxalone (Skelaxin®) - See Muscle Relaxants

## Metoclopramide (Reglan®)

1. Restricted to 12 weeks of therapy for all formulations
2. If NFR approved, after 12 weeks, get periodic AIMS testing

## Moisturizers topical (all formulations except Vitamin A&D)

1. Failed a 30-day trial of two commissary moisturizers OR
2. Patient is indigent AND treatment is medically necessary. Orders are limited to 30 days in duration when approved on the basis of indigent status alone. If renewed, indigent status will be reassessed.

## Mometasone/formoterol (Dulera®) – See Long Acting Beta Agonists/Inhaled Corticosteroid (LABA/ICS)

## Montelukast (Singulair®)

1. **Asthma:** Third line agent in the treatment of asthma. Compliance with other medications must be shown (e.g., oral steroid inhalers).
2. **Allergic Rhinitis:** Third line agent after documented compliance with OTC antihistamine and nasal steroid. Copies of progress notes detailing symptoms and exam findings will be required.
3. **Urticaria:** Montelukast will not be approved for this indication.

## Muscle Relaxants: dantrolene (Dantrium®), baclofen (Lioresal®), cyclobenzaprine (Flexeril®), tizanidine (Zanaflex®), metaxalone (Skelaxin®), methocarbamol (Robaxin®), carisprodal (Soma®), chlorzoxazone (Parafon forte DSC®), orphenadrine (Norflex®)

Approval for muscle relaxants will be considered for the following cases and all must be administered via DIRECTLY OBSERVED THERAPY:

1. Observable, documented muscle spasm due to:
   a. Multiple sclerosis
   b. Spinal cord injury or intrinsic cord lesions (not herniated spinal discs, not low back pain due to muscle spasm)
   c. Stroke
   d. Cerebral palsy
2. Approval for baclofen may be considered for intractable pain from neurological conditions, such as trigeminal neuralgia, that has been unresponsive to formulary agents.
3. Metaxalone is last resort skeletal muscle therapy after failure of all other muscle relaxants.

Compliance should be monitored at each visit. These medications are frequently diverted to other inmates due to their mood-altering effects. Abrupt discontinuation of baclofen can precipitate a drug withdrawal syndrome. There are generally no valid indications for long-term use of cyclobenzaprine or similar "muscle relaxants" such as methocarbamol. Lorazepam is recommended for short-term use in acute muscle spasm where sedation is desired.

## Naphazoline-pheniramine Ophthalmic drops (Visine-A®, Opcon A®)

1. Initiated by an optometrist or ophthalmologist with ongoing evaluation AND
2. Failure of commissary alternatives OR patient is indigent AND treatment is medically necessary. Orders are limited to 3 days.

## Narcolepsy Treatment - Stimulant medications: amphetamine, dextroamphetamine, modafinil, methylphenidate, selegiline

1. Documented verification of the inmate's report, to include polysomnography obtained and provided.
2. Patient has failed non-pharmacologic management strategies.
3. Functional impairment with work assignment, institution security, academic needs.
4. Failed treatment with modafinil and fluoxetine (for cataplexy).

## Neuraminidase inhibitors: oseltamivir (TamiFlu®), zanamivir (Relenza®)

1. Therapy is only to be offered to patients within 48 hours of exposure. Antiviral therapy is not effective or recommended 48 hours post exposure.
2. Non-Formulary Drug requests for TamiFlu® will be processed and expedited through Central Office.

# Bureau of Prisons
## Health Services
## Winter 2022 National Formulary Part 2

**IV Refrigeration:** N/A
**DEA Schedule:** N/A
**Medi-Span Rt:** N/A
**Dosage Forms:** N/A
**Changes Since:** N/A

**Part. GPI Cd:** N/A
**Project Group:** N/A
**IV Type:** N/A
**MLP Requires Cosign:** No
**Include Diagnosis:** No

**Item Type:** N/A
**Pill Line Only:** No
**Requires Crushing:** No
**Form./Non:** Formulary
**MRC Use Only:** No

**MRC Init. Only:** No
**Include Advisory:** Yes
**Include. Default Sig:** No
**Include Look/Sound:** No
**Non Substitutable:** No

**Include NF Use Criteria:** Yes
**Include Restrictions:** Yes
**Unit Dose:** No **Active Loc.:** No
**Active:** No
**Medguide:** No

| Doctor Name / Item Name | Dosage Form | GPI Code | Non Sub. | DEA Schd. | MLP Cosign | Bulk | Pill Ln Only | Req. Crush. | Active Loc. | Unit Dose | Fmlry |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Abacavir Sulfate (ABC) Oral Soln 20mg/ml | | | | | | | | | | | |
| Abacavir Sulfate(ABC) Oral Soln 20 MG/ML 240ml (Ziagen) | Sol | 12105005102020 | No | 0 | Yes | Yes | No | No | N/A | No | Yes |
| **MLP Requires Cosign** | | | | | | | | | | | |
| Abacavir Sulfate (ABC) Tablet | | | | | | | | | | | |
| Abacavir (ABC) 300 MG TAB UD (Ziagen) | Tab | 12105005100320 | No | 0 | Yes | No | No | No | N/A | Yes | Yes |
| Abacavir (ABC) 300 MG TAB (Ziagen) | Tab | 12105005100320 | No | 0 | Yes | No | No | No | N/A | No | Yes |
| **MLP Requires Cosign** | | | | | | | | | | | |
| Abacavir Sulfate/Lamivudine 600mg/300 mgTablet | | | | | | | | | | | |
| Abacavir Sulfate/Lamivudine 600MG/300MG TAB (Epzicom) | Tab | 12109902200340 | No | 0 | Yes | No | No | No | N/A | No | Yes |
| Abacavir Sulfate/Lamivudine 600MG/300MG Tab UD (Epzicom) | Tab | 12109902200340 | No | 0 | Yes | No | No | No | N/A | Yes | Yes |
| **MLP Requires Cosign** | | | | | | | | | | | |
| Abacavir-Lamivudine-Zidovudine Tablet | | | | | | | | | | | |
| Abacavir-Lamivudine-Zidovud 300-150-300MG TAB UD (Trizivir) | Tab | 12109903200320 | No | 0 | Yes | No | No | No | N/A | Yes | Yes |
| Abacavir-Lamivudine-Zidovudine 300-150-300MG tab (Trizivir) | Tab | 12109903200320 | No | 0 | Yes | No | No | No | N/A | No | Yes |
| **MLP Requires Cosign** | | | | | | | | | | | |
| Ace Aerosol Spacer | | | | | | | | | | | |
| Ace Spacer | Miscellaneous | 97100000006300 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| Acetaminophen 325 MG Tablet | | | | | | | | | | | |
| Acetaminophen 325 MG Tab (Tylenol) | Tab | 64200010000310 | No | 0 | No | No | No | No | N/A | No | Yes |
| Acetaminophen 325 MG Tab (OTC) 20 count (Tylenol) | Tab | 64200010000310 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| Acetaminophen 325 MG Tab (OTC) 24 count (Tylenol) | Tab | 64200010000310 | No | 0 | No | No | No | No | N/A | No | Yes |
| Acetaminophen 325 MG Tab (OTC) 50 count (Tylenol) | Tab | 64200010000310 | No | 0 | No | No | No | No | N/A | No | Yes |
| Acetaminophen 325 MG Tab (OTC) 100 count | Tab | 64200010000310 | No | 0 | No | No | No | No | N/A | No | Yes |
| Acetaminophen 325 MG Tab UD (Tylenol) | Tab | 64200010000310 | No | 0 | No | No | No | No | N/A | Yes | Yes |

| Doctor Name / Item Name | Dosage Form | GPI Code | Non Sub. | DEA Schd. | MLP Cosign | Bulk | Pill Ln Only | Req. Crush. | Active Loc. | Unit Dose | Fmlry |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **MLP Requires Cosign** | | | | | | | | | | | |
| Antihemophilic Factor-VWF Injection | | | | | | | | | | | |
| Antihemophilic Factor-VWF Soln 250-600 UNIT (Humate P) | Sol Recon | 85100015102122 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Antihemophilic Factor-VWF IV Kit 1000-1000 UNIT (Wilate) | Kit | 85100015106440 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Antihemophilic Factor-VWF IV Kit 500-500 UNIT (Wilate) | Kit | 85100015106430 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Antihemophilic Factor-VWF Soln 1000-2400 UNIT (Humate P) | Sol Recon | 85100015102144 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Antihemophilic/VWF Cmplex/Human IV Sol 2000 UNIT (Alphanate/Vwf) | Sol Recon | 85100015102193 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Antiheophilic Fac Humate-P IV Soln 500-1200 UNIT (Humate-P) | Sol Recon | 85100015102132 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Antihemophilic, factor VIII Injection | | | | | | | | | | | |
| Antihemophilic Fac VIII High(~1000)Koate-DVI IV (Koate-DVI Intravenous Soluti) | Sol Recon | 85100010002140 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Antihemophilic Fac VIII Med(~500)(Koate-DVI) IV (Koate-DVI) | Sol Recon | 85100010002130 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Antihemophilic fact, Koate-DVI IV Soln 250 UNIT (Koate-DVI) | Sol Recon | 85100010002110 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Apixaban Oral Tablet | | | | | | | | | | | |
| Apixaban 2.5 MG Tablet (Eliquis) | Tab | 83370010000320 | No | 0 | No | No | No | No | N/A | No | Yes |
| Apixaban 2.5 MG Tablet UD (Eliquis) | Tab | 83370010000320 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Apixaban 5 MG Tablet (Eliquis) | Tab | 83370010000330 | No | 0 | No | No | No | No | N/A | No | Yes |
| Apixaban 5 MG Tablet UD (Eliquis) | Tab | 83370010000330 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Apraclonidine 0.5% Ophthalmic Solution | | | | | | | | | | | |
| Apraclonidine HCl Ophthalmic Solution 0.5 % 10ML (Iopidine) | Sol | 86602010102010 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| Apraclonidine ophth 0.5% (5 ML) soln (Iopidine) | Sol | 86602010102010 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| Formulary Restrictions: ****OPHTHALMOLOGIST USE ONLY**** | | | | | | | | | | | |
| Apraclonidine 1% Ophthalmic Solution | | | | | | | | | | | |
| Apraclonidine ophth 1% (5 ML) soln (Iopidine) | Sol | 86602010102020 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| Apraclonidine Ophthalmic Solution 1% [0.1ml] (Iopidine) | Sol | 86602010102020 | No | 0 | No | Yes | No | No | N/A | Yes | Yes |
| Formulary Restrictions: ****OPHTHALMOLOGIST USE ONLY**** | | | | | | | | | | | |
| Aprepitant Capsule | | | | | | | | | | | |
| Aprepitant 125 MG CAP (Emend) | Cap | 50280020000130 | No | 0 | No | No | No | No | N/A | No | Yes |
| Aprepitant 125 MG Cap UD (Emend) | Cap | 50280020000130 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Aprepitant 3 day pack 1x125mg, 2x80mg Cap (Emend) | Miscellaneous | 50280020006320 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| Aprepitant 40 MG Capsule UD (Emend) | Cap | 50280020000110 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Aprepitant 80 MG CAP (Emend) | Cap | 50280020000120 | No | 0 | No | No | No | No | N/A | No | Yes |
| Aprepitant 80 MG Cap UD (Emend) | Cap | 50280020000120 | No | 0 | No | No | No | No | N/A | Yes | Yes |

| Doctor Name / Item Name | Dosage Form | GPI Code | Non Sub. | DEA Schd. | MLP Cosign | Bulk | Pill Ln Only | Req. Crush. | Active Loc. | Unit Dose | Fmly |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hydrogen Peroxide 3%** | | | | | | | | | | | |
| Hydrogen Peroxide 3%, 120 ML (Hydrogen Peroxide 3%) | Sol | 92000020002010 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| Hydrogen Peroxide 3%, 236 ML | Sol | 92000020002010 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| Hydrogen Peroxide 3%, 480 ML (Hydrogen Peroxide 3%) | Sol | 92000020002010 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| **Hydroxychloroquine Tablet** | | | | | | | | | | | |
| Hydroxychloroquine 200 MG TAB (Plaquenil 200 MG) | Tab | 13000020100305 | No | 0 | No | No | No | No | N/A | No | Yes |
| Hydroxychloroquine 200 MG TAB UD (Plaquenil) | Tab | 13000020100305 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Hydroxychloroquine Sulfate 100 MG Tablet | Tab | 13000020100303 | No | 0 | No | No | No | No | N/A | No | Yes |
| Hydroxychloroquine Sulfate 300 MG Tablet | Tab | 13000020100308 | No | 0 | No | No | No | No | N/A | No | Yes |
| Advisories: | | | | | | | | | | | |
| ****OPHTHALMIC EXAMS REQUIRED ( REFER TO DRUG REFERENCE)**** | | | | | | | | | | | |
| **HydroxyUREA Capsule** | | | | | | | | | | | |
| HydroxyUREA 500 MG Cap (Hydrea) | Cap | 21700030000105 | No | 0 | No | No | No | No | N/A | No | Yes |
| HydroxyUREA 500 MG Cap UD (Hydrea) | Cap | 21700030000105 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Formulary Restrictions: | | | | | | | | | | | |
| **"Limit to 14 days dispensing if cost is > $25 per tablet/capsule"** | | | | | | | | | | | |
| **hydrOXYzine HCL Inj** | | | | | | | | | | | |
| hydrOXYzine HCl 25 MG/ML, 1 ML Inj (Atarax) | Sol | 57200040102005 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| hydrOXYzine HCl 50 MG/ML, 1 ML Inj (vistaril) | Sol | 57200040102010 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| hydrOXYzine HCl 50 MG/ML, 2 ML Inj (Vistaril) | Sol | 57200040102010 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| HydrOXYzine HCl IM Soln 50 MG/ML 10ML | Sol | 57200040102010 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Advisories: | | | | | | | | | | | |
| ****RESTRICTED TO INJECTABLE FORMULATION ONLY** **INTRAMUSCULAR BENZTROPINE IS THE DRUG OF CHOICE FOR TREATMENT OF ACUTE DYSTONIC REACTIONS, OR FOR EMERGENCY MEDICATION IN COMBINATION WITH HALOPERIDOL AND LORAZEPAM**** | | | | | | | | | | | |
| **hydrOXYzine Tablets** | | | | | | | | | | | |
| hydrOXYzine HCl 10 MG Tab (Atarax) | Tab | 57200040100305 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| hydrOXYzine HCl 10 MG Tab UD (Atarax) | Tab | 57200040100305 | No | 0 | No | No | Yes | No | N/A | Yes | Yes |
| hydrOXYzine HCl 10 MG Tab UD (repack) (Atarax) | Tab | 57200040100305 | No | 0 | No | No | Yes | No | N/A | Yes | Yes |
| hydrOXYzine HCl 25 MG Tab (Atarax) | Tab | 57200040100310 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| hydrOXYzine HCl 25 MG Tab UD (Atarax) | Tab | 57200040100310 | No | 0 | No | No | Yes | No | N/A | Yes | Yes |
| hydrOXYzine HCl 50 MG Tab (Atarax) | Tab | 57200040100315 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| hydrOXYzine HCl 50 MG Tab UD (Atarax) | Tab | 57200040100315 | No | 0 | No | No | Yes | No | N/A | Yes | Yes |
| Advisories: | | | | | | | | | | | |
| ****NOT TO BE ROUTINELY USED AS A SLEEP AGENT** **INTRAMUSCULAR BENZTROPINE IS THE DRUG OF CHOICE FOR TREATMENT OF ACUTE DYSTONIC REACTIONS, OR FOR EMERGENCY MEDICATION IN COMBINATION WITH HALOPERIDOL AND LORAZEPAM**** | | | | | | | | | | | |
| Non-Formulary Use Criteria: | | | | | | | | | | | |
| **1. Formulary - MRC use only, restricted to dialysis** | | | | | | | | | | | |
| **2. Patients taking antipsychotic medication with extrapyramidal symptoms not responsive to benztropine and trihexyphenidyl (diphenhydramine and hydroxyzine only).** | | | | | | | | | | | |
| **3. Excessive salivation with clozapine (diphenhydramine and hydroxyzine only).** | | | | | | | | | | | |
| **4. Chronic idiopathic urticaria (consider other formulary H2 blockers such as doxepin).** | | | | | | | | | | | |
| **5. Chronic pruritus-associated dialysis (diphenhydramine and hydroxyzine only).** | | | | | | | | | | | |
| **6. Non-formulary use approved via DIRECTLY OBSERVED THERAPY ONLY for sedating antihistamines: diphenhydramine, hydroxyzine, & cyproheptadine.** | | | | | | | | | | | |
| **7. Urticaria: Classified according to etiology or precipitating factor. All potential precipitating factors have been considered and controlled.** | | | | | | | | | | | |
| **8. Urticaria: IgE levels and/or absolute eosinophil count in conditions where this is typically seen.** | | | | | | | | | | | |

| Doctor Name / Item Name | Dosage Form | GPI Code | Non Sub. | DEA Schd. | MLP Cosign | Bulk | Pill Ln Only | Req. Crush. | Active Loc. | Unit Dose | Fmly |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Immune Globulin, Human | | | | | | | | | | | |
| Immune Globulin (Flebogamma DIF) IV 0.5 GM/10ML (Flebogamma) | Sol | 19100020102020 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |
| Immune Globulin (Flebogamma DIF) IV 10 GM/100ML (Flebogamma) | Sol | 19100020102072 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |
| Immune Globulin (Flebogamma DIF) IV 10 GM/200ML (Flebogamma) | Sol | 19100020102042 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |
| Immune Globulin (Flebogamma DIF) IV 2.5 GM/50ML (Flebogamma) | Sol | 19100020102034 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |
| Immune Globulin (Flebogamma DIF) IV 20 GM/200ML | Sol | 19100020102076 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Immune Globulin (Flebogamma DIF) IV 20 GM/400ML (Flebogamma) | Sol | 19100020102044 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |
| Immune Globulin (Flebogamma DIF) IV 5 GM/100ML (Flebogamma) | Sol | 19100020102038 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |
| Immune Globulin (Gamunex) IV Soln 5 GM/50ML (Gamunex) | Sol | 19100020102068 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Immune Globulin (Gamunex) IV Soln 20 GM/200ML10% (Gamunex) | Sol | 19100020102076 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Immune Globulin (Octagam) IV Soln 10 GM/100ML (Octagam) | Sol | 19100020102072 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Immune Globulin (Octagam) IV Soln 20 GM/200ML | Sol | 19100020102076 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Indinavir Sulfate (IDV) Capsules | | | | | | | | | | | |
| Indinavir Sulfate (IDV) 200 MG Cap (Crixivan) | Cap | 12104530200120 | No | 0 | Yes | No | No | No | N/A | No | Yes |
| Indinavir Sulfate (IDV) 200 MG Cap UD (Crixivan) | Cap | 12104530200120 | No | 0 | Yes | No | No | No | N/A | Yes | Yes |
| Indinavir Sulfate (IDV) 400 MG Cap (Crixivan) | Cap | 12104530200140 | No | 0 | Yes | No | No | No | N/A | No | Yes |
| Indinavir Sulfate (IDV) 400 MG Cap UD (Crixivan) | Cap | 12104530200140 | No | 0 | Yes | No | No | No | N/A | Yes | Yes |
| **MLP Requires Cosign** | | | | | | | | | | | |
| ~~Indomethacin Capsule~~ | | | | | | | | | | | |
| Indomethacin 25 MG Cap (Indocin) | Cap | 66100030000105 | No | 0 | No | No | No | No | N/A | No | Yes |
| Indomethacin 25 MG Cap UD (Indocin) | Cap | 66100030000105 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Indomethacin 50 MG Cap (Indocin) | Cap | 66100030000110 | No | 0 | No | No | No | No | N/A | No | Yes |
| Indomethacin 50 MG Cap UD (Indocin) | Cap | 66100030000110 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Indomethacin Suspension 25 MG/5ML | | | | | | | | | | | |
| Indomethacin 25 MG/5ML suspension 237ml (Indocin) | Susp | 66100030001805 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| Influenza (Afluria) PF Im Susp Syringe 0.5ML | | | | | | | | | | | |
| Influenza (Afluria) PF Im Susp Prefill Syr 0.5ML (Afluria) | Susp Prefilled | 1710002021E620 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Influenza (Afluria) Quadrival IM SUSP | | | | | | | | | | | |
| Influenza (Afluria) Quadrival IM Syringe 0.5 ML (Afluria prefilled Syringe) | Susp Prefilled | 1710002025E620 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |
| Influenza (Afluria) Quadrival IM Syringe 0.25 ML | | | | | | | | | | | |
| Influenza (Afluria) Quadrival IM Syringe 0.25 ML (Afluria) | Susp Prefilled | 1710002025E610 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |

| Doctor Name / Item Name | Dosage Form | GPI Code | Non Sub. | Non Schd. | DEA Cosign | MLP Bulk | Pill Ln Only | Req. Crush. | Active Loc. | Unit Dose | Fmlry |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Methenamine Mandelate Tab** | | | | | | | | | | | |
| Methenamine Mandelate 1 GM Tab (Mandelamine) | Tab | 16800020100320 | No | 0 | No | No | No | No | N/A | No | Yes |
| Methenamine Mandelate 500 MG Tab (Mandelamine) | Tab | 16800020100310 | No | 0 | No | No | No | No | N/A | No | Yes |
| **Methimazole Tablet** | | | | | | | | | | | |
| Methimazole 5 MG Tab (Tapazole) | Tab | 28300010000305 | No | 0 | No | No | No | No | N/A | No | Yes |
| Methimazole 5 MG Tab UD (Tapazole) | Tab | 28300010000305 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Methimazole 10 MG Tab (Tapazole) | Tab | 28300010000310 | No | 0 | No | No | No | No | N/A | No | Yes |
| Methimazole 10 MG Tab UD (Tapazole) | Tab | 28300010000310 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| **Methotrexate Sodium Inj** | | | | | | | | | | | |
| Methotrexate Sodium (PF) Inj Soln 1 GM/40ML | Sol | 21300050102075 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Methotrexate Sodium (PF) Inj Soln 250 MG/10ML | Sol | 21300050102069 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Methotrexate Sodium (PF) Inj Soln 50 MG/2ML | Sol | 21300050102063 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Methotrexate Sodium Inj Solution 250 MG/10ML | Sol | 21300050102068 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Methotrexate Sodium Injection Soln 1 GM | Sol Recon | 21300050102150 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Methotrexate Sodium Injection Solution 50 MG/2ML | Sol | 21300050102062 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Advisories: | | | | | | | | | | | |
| **"Warning, designated high risk Medication! Ensure appropriate medication, dose, frequency, indication and monitoring."** | | | | | | | | | | | |
| **Methotrexate Sodium Tablet** | | | | | | | | | | | |
| Methotrexate Sodium 10 MG Tab | Tab | 21300050100340 | No | 0 | No | No | No | No | N/A | No | Yes |
| Methotrexate Sodium 2.5 MG Tab (Methotrexate Sodium) | Tab | 21300050100310 | No | 0 | No | No | No | No | N/A | No | Yes |
| Methotrexate Sodium 2.5 MG Tab UD (Methotrexate) | Tab | 21300050100310 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Advisories: | | | | | | | | | | | |
| **"Warning, designated high risk Medication! Ensure appropriate medication, dose, frequency, indication and monitoring."** | | | | | | | | | | | |
| Formulary Restrictions: | | | | | | | | | | | |
| **"Limit to 14 days dispensing if cost is > $25 per tablet/capsule"** | | | | | | | | | | | |
| **Methoxsalen Capsule** | | | | | | | | | | | |
| Methoxsalen 10 MG Cap (Oxsoralen-Ultra 10 MG) | Cap | 90250560100110 | No | 0 | No | No | No | No | N/A | No | Yes |
| **Methyldopa Tablet** | | | | | | | | | | | |
| Methyldopa 250 MG Tab (Aldomet) | Tab | 36201030000310 | No | 0 | No | No | No | No | N/A | No | Yes |
| Methyldopa 250 MG Tab UD (Aldomet) | Tab | 36201030000310 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Methyldopa 500 MG Tab (Aldomet) | Tab | 36201030000315 | No | 0 | No | No | No | No | N/A | No | Yes |
| Methyldopa 500 MG Tab UD (Aldomet) | Tab | 36201030000315 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Advisories: | | | | | | | | | | | |
| ****PREFERRED AGENT FOR HYPERTENSION OF PREGNANCY, PRE-ECLAMPSIA, ECLAMPSIA*** | | | | | | | | | | | |
| **Methylene Blue Inj 1%** | | | | | | | | | | | |
| Methylene Blue Inj 1%, 10 ML (Methylene Blue) | Sol | 93000050002005 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |
| Methylene Blue Intravenous Solution 50 MG/10ML (ProvayBlue) | Sol | 93000050002030 | No | 0 | No | No | Yes | No | N/A | No | Yes |

| Doctor Name / Item Name | Dosage Form | GPI Code | Non Sub. | DEA Schd. | MLP Cosign | Bulk | Pill Ln Only | Req. Crush. | Active Loc. | Unit Dose | Fmlry |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Mirtazapine Tablet | | | | | | | | | | | |
| Mirtazapine 7.5 MG Tab (Remeron) | Tab | 58030050000308 | No | 0 | No | No | No | No | N/A | No | Yes |
| Mirtazapine 7.5 MG Tab UD (Remeron) | Tab | 58030050000308 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Mirtazapine 15 MG Tab (Remeron) | Tab | 58030050000315 | No | 0 | No | No | No | No | N/A | No | Yes |
| Mirtazapine 15 MG Tab UD (Remeron) | Tab | 58030050000315 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Mirtazapine 30 MG Tab (Remeron) | Tab | 58030050000330 | No | 0 | No | No | No | No | N/A | No | Yes |
| Mirtazapine 30 MG Tab UD (Remeron) | Tab | 58030050000330 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Mirtazapine 45 MG Tab (Remeron) | Tab | 58030050000345 | No | 0 | No | No | No | No | N/A | No | Yes |
| Mirtazapine 45 MG Tab UD (Remeron) | Tab | 58030050000345 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Advisories: | | | | | | | | | | | |
| ****NOT TO BE ROUTINELY USED AS A SLEEP AGENT**** | | | | | | | | | | | |
| Misoprostol Tablet | | | | | | | | | | | |
| Misoprostol 100 MCG Tab (Cytotec) | Tab | 49250030000310 | No | 0 | No | No | No | No | N/A | No | Yes |
| Misoprostol 100 MCG Tab UD (Cytotec) | Tab | 49250030000310 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Misoprostol 200 MCG Tab (Cytotec) | Tab | 49250030000320 | No | 0 | No | No | No | No | N/A | No | Yes |
| Misoprostol 200 MCG Tab UD (Cytotec) | Tab | 49250030000320 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Mitomycin Inj | | | | | | | | | | | |
| Mitomycin 5 MG Inj (Mutamycin) | Sol Recon | 21200050002105 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Mitomycin 20 MG Inj (Mutamycin) | Sol Recon | 21200050002110 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Mitomycin 40 MG Inj (Mutamycin) | Sol Recon | 21200050002120 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| Mitotane Tablet | | | | | | | | | | | |
| Mitotane 500 MG Tab (Lysodren) | Tab | 21402250000320 | No | 0 | No | No | No | No | N/A | No | Yes |
| Formulary Restrictions: | | | | | | | | | | | |
| **"Limit to 14 days dispensing if cost is > $25 per tablet/capsule"** | | | | | | | | | | | |
| MitoXANTRONE HCL Inj | | | | | | | | | | | |
| MitoXANTRONE HCl IV Concentrate 20 MG/10ML | Concentrate | 21200055001320 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| mitoXANTRONE HCl IV Concentrate 25 MG/12.5ML | Concentrate | 21200055001325 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| mitoXANTRONE HCl IV Concentrate 30 MG/15ML | Concentrate | 21200055001330 | No | 0 | No | No | Yes | No | N/A | No | Yes |
| **Medical Referral Center (MRC) Use Only** | | | | | | | | | | | |
| Moderna COVID-19 Vaccine IM Susp 100 MCG/0.5ML | | | | | | | | | | | |
| Moderna COVID-19 Vaccine IM 100 MCG/0.5ML 5 ML (Moderna) | Susp | 17100002401840 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |
| Moderna COVID-19 Vaccine IM 100 MCG/0.5ML 7 ML | Susp | 17100002401840 | No | 0 | No | Yes | Yes | No | N/A | No | Yes |
| Mometasone Furoate 110 MCG/Inh | | | | | | | | | | | |
| Mometasone Furoate Inhal 110 MCG/Inh [30 doses] (Asmanex 30 Metered Doses) | Aero Pwdr | 44400036208010 | No | 0 | No | Yes | No | No | N/A | No | Yes |

| Doctor Name / Item Name | Dosage Form | GPI Code | Non Sub. | DEA Schd. | MLP Cosign | Bulk | Pill Ln Only | Req. Crush. | Active Loc. | Unit Dose | Fmlry |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Povidone-Iodine Swab 10% | | | | | | | | | | | |
| Povidone-Iodine Swab 10% (Betadine Swabsticks) | Swab | 92200040009420 | No | 0 | No | Yes | No | No | N/A | No | Yes |
| Pravastatin Tablet | | | | | | | | | | | |
| Pravastatin 10 MG Tab (Pravachol) | Tab | 39400065100320 | No | 0 | No | No | No | No | N/A | No | Yes |
| Pravastatin 10 MG Tab UD | Tab | 39400065100320 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Pravastatin 20 MG Tab (Pravachol) | Tab | 39400065100330 | No | 0 | No | No | No | No | N/A | No | Yes |
| Pravastatin 40 MG Tab (Pravachol) | Tab | 39400065100340 | No | 0 | No | No | No | No | N/A | No | Yes |
| Pravastatin 80 MG Tab (Pravachol) | Tab | 39400065100360 | No | 0 | No | No | No | No | N/A | No | Yes |
| Pravastatin 80 MG Tab UD (Pravachol) | Tab | 39400065100360 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Pravastatin Sodium 20 MG Tab UD (Pravachol) | Tab | 39400065100330 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Pravastatin Sodium 40 MG Tab UD (Pravachol) | Tab | 39400065100340 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Prazosin Capsule | | | | | | | | | | | |
| Prazosin Cap 1 MG (Minipress) | Cap | 36202030100105 | No | 0 | No | No | No | No | N/A | No | Yes |
| Prazosin Cap 1 MG UD (Minipress) | Cap | 36202030100105 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Prazosin Cap 2 MG (Minipress) | Cap | 36202030100110 | No | 0 | No | No | No | No | N/A | No | Yes |
| Prazosin Cap 2 MG UD (Minipress) | Cap | 36202030100110 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| Prazosin Cap 5 MG (Minipress) | Cap | 36202030100115 | No | 0 | No | No | No | No | N/A | No | Yes |
| Prazosin Cap 5 MG UD (Minipress) | Cap | 36202030100115 | No | 0 | No | No | No | No | N/A | Yes | Yes |
| prednisoLONE Ace. ophth susp 0.12% | | | | | | | | | | | |
| prednisoLONE Ace. Ophth Susp 0.12%, 10ML | Susp | 86300050101809 | No | 0 | Yes | Yes | No | No | N/A | No | Yes |
| prednisoLONE Ace. Ophth Susp 0.12%, 5ml (Pred Mild) | Susp | 86300050101809 | No | 0 | Yes | Yes | No | No | N/A | No | Yes |
| Formulary Restrictions: ****RESTRICTED TO OPTOMETRIST OR PHYSICIAN USE ONLY** **COMBINATION SULFACETAMIDE/PREDNISOLONE OPHTHALMIC PREPARATON (BLEPHAMIDE) NOT APPROVED**** | | | | | | | | | | | |
| **MLP Requires Cosign** | | | | | | | | | | | |
| prednisoLONE Ace. ophth susp 1% | | | | | | | | | | | |
| prednisoLONE Ace. Ophth Susp 1%, 5 ml (Pred Forte) | Susp | 86300050101815 | No | 0 | Yes | Yes | No | No | N/A | No | Yes |
| prednisoLONE Ace. Ophth Susp 1%, 10 ml (Pred Forte) | Susp | 86300050101815 | No | 0 | Yes | Yes | No | No | N/A | No | Yes |
| prednisoLONE Ace. Ophth Susp 1%, 15 ml (Pred Forte) | Susp | 86300050101815 | No | 0 | Yes | Yes | No | No | N/A | No | Yes |
| PrednisoLONE Forte Ophth Suspension 1% 1 ML (Pred Forte) | Susp | 86300050101815 | No | 0 | Yes | Yes | No | No | N/A | No | Yes |
| Formulary Restrictions: ****RESTRICTED TO OPTOMETRIST OR PHYSICIAN USE ONLY** **COMBINATION SULFACETAMIDE/PREDNISOLONE OPHTHALMIC PREPARATON (BLEPHAMIDE) NOT APPROVED**** | | | | | | | | | | | |
| **MLP Requires Cosign** | | | | | | | | | | | |
| prednisoLONE Sod Phos ophth Solution 1% | | | | | | | | | | | |
| prednisoLONE Sod Phos ophth 1%, 10ml (AK-Pred Ophthalmic Solution) | Sol | 86300050202015 | No | 0 | Yes | Yes | No | No | N/A | No | Yes |

| Doctor Name / Item Name | Dosage Form | GPI Code | Non Sub. | DEA Schd. | Cosign | ML | Bulk | Pill Ln Only | Crush. Req. | Loc. Active | Dose Unit | Fmlry |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Formulary Restrictions: ****RESTRICTED TO OPTOMETRIST OR PHYSICIAN USE ONLY** **COMBINATION SULFACETAMIDE/PREDNISOLONE OPHTHALMIC PREPARATON (BLEPHAMIDE) NOT APPROVED**** **MLP Requires Cosign** | | | | | | | | | | | | |
| predniSONE 10 mg Dosepak (21) | | | | | | | | | | | | |
| predniSONE 10 MG Therapy Pack [21 ct] (Sterapred DS) | Tab Therapy | 2210004500B720 | No | 0 | No | Yes | No | No | N/A | No | Yes | |
| predniSONE 10 mg Dosepak (48) | | | | | | | | | | | | |
| predniSONE 10 MG Therapy Pack [48 ct] (Sterapred DS) | Tab Therapy | 2210004500B725 | No | 0 | No | Yes | No | No | N/A | No | Yes | |
| predniSONE 5 mg Dosepack #21 | | | | | | | | | | | | |
| predniSONE 5 MG Therapy Pack [21 ct] (Deltasone) | Tab Therapy | 2210004500B705 | No | 0 | No | Yes | No | No | N/A | No | Yes | |
| predniSONE 5 mg Dosepack #48 | | | | | | | | | | | | |
| predniSONE 5 MG Therapy Pack [48 ct] (Sterapred DS) | Tab Therapy | 2210004500B710 | No | 0 | No | Yes | No | No | N/A | No | Yes | |
| predniSONE Solution 1 MG/ML | | | | | | | | | | | | |
| predniSONE Solution 1 MG/ML | Sol | 22100045002005 | No | 0 | No | Yes | No | No | N/A | No | Yes | |
| predniSONE Solution 1 MG/ML, 5ML UD | Sol | 22100045002005 | No | 0 | No | Yes | No | No | N/A | Yes | Yes | |
| predniSONE Solution 5 MG/ML | | | | | | | | | | | | |
| predniSONE Solution 5 MG/ML, 30ML (PredniSONE Intensol) | Concentrate | 22100045001310 | No | 0 | No | Yes | No | No | N/A | No | Yes | |
| predniSONE Tablet | | | | | | | | | | | | |
| predniSONE 1 MG Tab (Deltasone) | Tab | 22100045000305 | No | 0 | No | No | No | No | N/A | No | Yes | |
| predniSONE 1 MG Tab UD (Deltasone) | Tab | 22100045000305 | No | 0 | No | No | No | No | N/A | Yes | Yes | |
| predniSONE 2.5 MG Tab (Deltasone) | Tab | 22100045000310 | No | 0 | No | No | No | No | N/A | No | Yes | |
| predniSONE 2.5 MG Tab UD (Deltasone) | Tab | 22100045000310 | No | 0 | No | No | No | No | N/A | Yes | Yes | |
| predniSONE 5 MG Tab (Deltasone) | Tab | 22100045000315 | No | 0 | No | No | No | No | N/A | No | Yes | |
| predniSONE 5 MG Tab UD (Deltasone) | Tab | 22100045000315 | No | 0 | No | No | No | No | N/A | Yes | Yes | |
| predniSONE 10 MG Tab (Deltasone) | Tab | 22100045000320 | No | 0 | No | No | No | No | N/A | No | Yes | |
| predniSONE 10 MG Tab UD (Deltasone) | Tab | 22100045000320 | No | 0 | No | No | No | No | N/A | Yes | Yes | |
| predniSONE 20 MG Tab (Deltasone) | Tab | 22100045000325 | No | 0 | No | No | No | No | N/A | No | Yes | |
| predniSONE 20 MG Tab UD (Deltasone) | Tab | 22100045000325 | No | 0 | No | No | No | No | N/A | Yes | Yes | |
| predniSONE 50 MG Tab (Deltasone) | Tab | 22100045000335 | No | 0 | No | No | No | No | N/A | No | Yes | |
| predniSONE 50 MG Tab UD (Deltasone) | Tab | 22100045000335 | No | 0 | No | No | No | No | N/A | Yes | Yes | |
| PreHevbrio Intramuscular Suspension 10 MCG/ML | | | | | | | | | | | | |
| Hepatitis B vac PreHevbrio IM Susp 10 MCG/ML (PreHevbrio) | Susp | 17100010401820 | No | 0 | No | No | Yes | No | N/A | No | Yes | |

Enclosure 1



# COVID-19 Modified Operations Plan & Matrix

This page provides a general overview about BOP COVID-19 Operational Levels: how they are determined, how operations are affected, and related resources.

COVID-19 statistics and related resources



## About Operational Levels

Institutions determine their operational level (Level 1, Level 2, or Level 3) based on two indicators of COVID-19 Risk: the facilities' COVID-19 inmate isolation rate and the COVID-19 community risk of the county where the facility is located."[1].

At each level, an infection prevention procedure or modification to operations (such as inmate programming and services) may be made to mitigate the risk and spread of COVID-19 in accordance with BOP pandemic guidance. BOP pandemic guidance follows and integrates guidance and direction from CDC, OSHA, DOJ, and established medical best practices

## Level Rating Procedure

1. *Institutions* determine their operational level and modifications based on two indicators of COVID-19 Risk: the facilities' COVID-19 inmate isolation rate and the COVID-19 community risk of the county where the facility is located.

2. The *Health Services Administrator* (or designee) will review the COVID-19 Protocol Matrix Data dashboard daily and communicate the facility's operational level to the institution *Executive Staff*, *local Union President*, and *Operations Lieutenant* (or designee).

## Level Indicators

BOP COVID-19 Operational Levels are raised or lowered after 48 hours of respective sustained increases or decreases in the following indicators:

Enclosure 1

**Level 1**

*IF*

Medical isolation rate < 2%

*AND*

New community positive cases < 100 per 100,000 over the last 7 days

**Level 2**

*IF*

Medical isolation rate 2% to < 7%

*OR*

New community positive cases ≥ 100 and < 200 per 100,000 over the last 7 days

**Level 3**

*IF*

Medical isolation rate ≥ 7%

*OR*

New community positive cases ≥ 200 per 100,000 over the last 7 days



# Level-Specific Modifications

The following modifications are made depending upon the operational level of the institution.

## Infection Prevention Procedures Modifications (Level-Specific)

Please note: Medical isolation, contact tracing, and PPE appropriate for each setting are still in effect for all scenarios.

| | Level 1 Operations  | Level 2 Operations  | Level 3 Operations  |
|---|---|---|---|
| **Cohorting** | Modifications not necessary | Modifications not necessary if social distancing is followed | Modifications necessary |
| **Face Covering** | • Indoors: Recommended at MRCs Optional at Care Levels 1 thru 3, FTC, holdover, bus hub, and detention centers (except in patient care areas, when all inmates must wear face coverings)<br>• Outdoors: Not required | • Required at all times in all indoor environments<br>• Face covering required when social distancing is not possible outdoors | Follow the full COVID-19 Pandemic Plan including facility-wide use of face coverings, surgical or N95 masks as indicated. |
| **Social Distancing** | • All health care units and patient care areas<br>• Not necessary in other locations | All areas | All areas |
| **Staff/Visitor/Volunteer Symptom Screening** | Self monitoring/report symptoms of COVID-19 | Self monitoring/report symptoms of COVID-19 | Implement daily COVID-19 symptom screen for entry into the institution (enhanced screening) |

## Inmate Programming and Services Modifications (Level-Specific)

Please note: Each activity will follow the general infection prevention recommendations above unless specified otherwise below.

| | Level 1 Operations ⓘ | Level 2 Operations ⓘ | Level 3 Operations ⓘ |
|---|---|---|---|
| | 1 | 2 | 3 |
| **Barber / Beauty Shop** | Normal operations | Limit capacity to allow for social distancing | Follow the COVID-19 Pandemic Plan |
| **Commissary / Inmate Phones/ TRULINCS** | Normal operations | • Limit capacity to allow for social distancing<br>• Cohorting if not able to social distance. | Follow the COVID-19 Pandemic Plan |
| **Laundry** | Normal operations | Limit capacity to allow for social distancing | Follow the COVID-19 Pandemic Plan |
| **Law Library** | Normal capacity participation | Limit capacity to allow for social distancing | Follow the COVID-19 Pandemic Plan |
| **Programs & Services (Education, Psychology, Religious Svs)** | Normal capacity participation | • Standard housing capacity (in Residential units)<br>• Limit capacity to allow for social distancing during group activities | Follow the COVID-19 Pandemic Plan |
| **Recreation** | Normal capacity participation | • Limit capacity levels to allow for social distancing indoors<br>• Normal outdoor capacity participation<br>• Face covering outdoors when social distancing is not possible | Follow the COVID-19 Pandemic Plan |
| **Transport (All: Bus, Air, Van)** | Double masking with a non-wire surgical mask covered by a face covering OR wire-free KN95 is required at all times. | Double masking with a non-wire surgical mask covered by a face covering OR wire-free KN95 is required at all times. | Double masking with a non-wire surgical mask covered by a face covering OR wire-free KN95 is required at all times. |
| **Visitation** | • Face covering is required for visitors as well as staff and inmates<br>• Normal operations | • Face covering is required for visitors as well as staff and inmates<br>• Non-contact only | Follow the COVID-19 Pandemic Plan |
| **Work Detail / Unicor** | Normal operations | • Cohorting if not social distancing<br>• Face covering outdoors when social distancing is not possible | Follow the COVID-19 Pandemic Plan |

Enclosure 1

# General Modifications

Many other general modifications, some of which are highlighted below, are in effect due to COVID-19, regardless of the facilities current operation level.

## Infection Prevention Procedures and Operational Modifications (General)

- High sanitation standards expected at all levels of operation. At a minimum, all areas, supplies, and equipment must be cleaned on a daily basis.
- Inmates are tested for SARS-CoV-2 when they are symptomatic, asymptomatic but exposed, during movements when indicated, and when surveillance is needed.
- Inmates with known or suspected SARS-CoV-2 infection should be provided a face covering, POC tested, and placed in medical isolation for 10 days.
- When transferring from one BOP location to another BOP location or correctional jurisdiction, a five or seven day intake observation period maybe indicated.
- All workers (staff/contractors/inmate orderlies) must wear a surgical mask in all patient care areas, whether or not there are patients in the clinic/area.
- When required, face coverings will be worn at all time while indoors, regardless of vaccination status (Guidance from DOJ memo).

Community Transmission Rate [1]

Community Risk: Congregate (prison) settings have higher COVID-19 infection transmission risk than the community at large. As such, the BOP Matrix uses a Hybrid Community Risk benchmark that is more aggressive than the Community Level used by the community at large, but less aggressive than the Community Transmission Rate used in hospitals and nursing facilities.

BOP continues to collaborate with CDC to further evaluate and evolve BOP Operational Levels in a manner to provide the least amount of disruption to visiting and institution programming while maintaining the highest level of protection to staff and inmate patients against COVID-19.



# Related Resources

- BOP COVID-19 Main Information and Resource Page
- BOP COVID-19 Response Overview
- CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities
- BOP COVID-19 Vaccine Guidance
- BOP COVID-19 Staff/Contractor/Visitor Screening Tool

Enclosure 2:

Medication Availability and Concerns

Table 1 depicts the medications Mr. Parks is currently taking, the availability of each drug and the concern at Butner Low (See Reference 4 and 5)

TABLE 1

| Medical Diagnosis | Medication | Formulary/Non-Formulary | Availability | Concerns | Reference |
|---|---|---|---|---|---|
| Sarcoidosos | Prednisone | Formulary | Yes | Requires consultation with a specialist | Ref 5- p.159 |
| Sarcoidosos | Methotrexate | Formulary | Limited to 14 days if cost is greater than $25 per tablet/capsule. | Requires consultation with a specialist | Ref 4 - p. 22<br>Ref 5 - p. 121 |
| Sarcoidosos | Fluticason Furoate | Non-Formulary | Yes | Needs Approval | Ref 4 - pgs 3 & 25 |
| Asthma | Montelukast | Formulary | Yes | Third line agent in the treatment of asthma | Ref 4 - p. 26 |
| Depression/Anxiety/PTSD/Insomnia | Mirtazapin | Formulary | Yes | Not to be routinely used as a sleep agent | Ref 5 - p. 127 |
| PTSD (Nightmares) | Prazosin | Formulary | Yes | None | Ref 5 - p. 158 |
| Muscle Spasms | Cyclobenzaprine | Non-Formulary | No | Requires pre-authorization, only for inmates with the following conditions: multiple sclerosis, spinal cord injury or intrinsic cord lesions, stroke | Ref 4 - p. 24 |
| Rheumatoid Arthritis | Indomethacin | Formulary | Yes | None | Ref 5 - p. 91 |
| Rheumatoid Arthritis | Plaquenil | Formulary | Yes | Generic Version - Need Consult | Ref 5 - p. 88 |
| Pulmonary Embolism | Apixaban | Formulary | Yes | None | Ref 5 - p.14 |

Enclosure 3

**U.S. Department of Justice**
**Federal Bureau of Prisons**

**FOR IMMEDIATE RELEASE**
March 28, 2022

Contact: Office of Public Affairs
202-514-6551

## Inmate Death at FCI Butner Medium I

WASHINGTON, D.C.: On Monday, January 10, 2022, inmate Marvin Hersch tested positive for COVID-19 at the Federal Correctional Institution (FCI) Butner Medium I in Butner, North Carolina, and was placed in medical isolation. Institution medical staff monitored Mr. Hersch's condition and provided treatment. On Thursday, January 13, 2022, Mr. Hersch's condition worsened, and he was transported to a local hospital. Upon return, Mr. Hersch was transferred to the Federal Medical Center (FMC) Butner in Butner, North Carolina, where he was placed on a ventilator and his condition was monitored. On Thursday, February 3, 2022, in accordance with Centers for Disease Control and Prevention (CDC) guidelines, Mr. Hersch was converted to a status of recovered, following the completion of medical isolation, and presenting with no symptoms.

On Friday, March 25, 2022, Mr. Hersch was transported to a local hospital due to Acute Respiratory Failure Secondary to Pneumonia. Subsequently, on Saturday, March 26, 2022, Mr. Hersch who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced deceased by medical staff.

Mr. Hersch was an 82-year-old male who was sentenced in the Southern District of Florida to a 1,260-month sentence for Transporting a Minor in Foreign Commerce with Intent to Engage in a Sexual Act. He had been in custody at Federal Correctional Complex Butner since October 30, 2000.

FCI Butner Medium I is a medium security facility that currently houses 545 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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Federal Bureau of Prisons

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# BOP COVID-19 Statistics

This page is intended to provide further transparency to our stakeholders about COVID-19 in the Federal Bureau of Prisons by providing additional statistic viewing options to enhance specific needs. The data sets come from multiple sources and may be updated at various times during the day and, therefore, should not be considered authoritative data for any legal or scientific purpose. For questions about the data not covered at the bottom of this page or on the BOP COVID-19 statistics and resources page, please contact our agency.

| Facility Code | Complex Code | Location Type | Facility Name | City | State | Zip Code | Operational Level | Staff Vaccinated | Inmates Vaccinated | Inmates Completed Tests | Inmates Pending Tests | Inmates Tested Positive | Staff Positive | Staff Recovered | Staff Deaths | Inmates Positive | Inmates Recovered | Inmates Deaths |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SPG | | BOP | Springfield MCFP | Springfield | MO | 65807 | 1 | 438 | 1160 | 812 | 0 | 385 | 0 | 462 | 0 | 0 | 267 | 20 |
| BUF | BUX | BOP | Butner Low FCI | Butner | NC | 27509 | 1 | 979* | 4083* | 736 | 0 | 267 | 0 | 152 | 2 | 0 | 329 | 18 |
| FTW | | BOP | Fort Worth FMC | Fort Worth | TX | 76119 | 1 | 262 | 1734 | 1329 | 0 | 576 | 0 | 76 | 0 | 10 | 506 | 18 |
| DEV | | BOP | Devens FMC | Ayer | MA | 01432 | 1 | 368 | 974 | 796 | 1 | 434 | 4 | 310 | 0 | 0 | 333 | 14 |
| TCP | TCX | BOP | Tucson USP | Tucson | AZ | 85756 | 1 | 442* | 1899* | 1359 | 0 | 851 | 0 | 266 | 0 | 1 | 803 | 13 |
| TRM | | BOP | Terminal Island FCI | San Pedro | CA | 90731 | 1 | 211 | 776 | 820 | 0 | 532 | 6 | 133 | 0 | 1 | 369 | 13 |
| BUT | BUX | BOP | Butner Medium I FCI | Butner | NC | 27509 | 1 | 979* | 4083* | 626 | 1 | 243 | 1 | 290 | 0 | 0 | 117 | 11 |
| LEX | | BOP | Lexington FMC | Lexington | KY | 40511 | 1 | 370 | 1561 | 1202 | 1 | 642 | 1 | 273 | 0 | 5 | 426 | 10 |
| ELK | | BOP | Elkton FCI | Lisbon | OH | 44432 | 1 | 235 | 1854 | 1596 | 0 | 531 | 0 | 116 | 0 | 3 | 518 | 9 |
| CRW | | BOP | Carswell FMC | Fort Worth | TX | 76127 | 2 | 335 | 1659 | 1243 | 0 | 897 | 1 | 113 | 0 | 24 | 741 | 8 |
| SEA | | BOP | Seagoville FCI | Seagoville | TX | 75159 | 1 | 189 | 2021 | 1546 | 0 | 1032 | 3 | 121 | 0 | 0 | 911 | 8 |
| OAK | OAX | BOP | Oakdale I FCI | Oakdale | LA | 71463 | 1 | 237* | 2227* | 890 | 0 | 692 | 0 | 106 | 0 | 7 | 634 | 7 |
| ASH | | BOP | Ashland FCI | Ashland | KY | 41105 | 1 | 172 | 1389 | 1125 | 0 | 430 | 0 | 197 | 0 | 1 | 288 | 6 |
| BUH | BUX | BOP | Butner FMC | Butner | NC | 27509 | 1 | 979* | 4083* | 706 | 0 | 262 | 0 | 322 | 0 | 1 | 242 | 6 |
| COM | COX | BOP | Coleman Medium FCI | Sumterville | FL | 33521 | 1 | 757* | 5473* | 1502 | 0 | 376 | 2 | 147 | 1 | 1 | 310 | 5 |
| TDG | | BOP | Talladega FCI | Talladega | AL | 35160 | 1 | 152 | 1017 | 940 | 0 | 331 | 0 | 103 | 0 | 0 | 277 | 5 |
| BML | BMX | BOP | Beaumont Low FCI | Beaumont | TX | 77705 | 1 | 453* | 4127* | 1659 | 0 | 716 | 0 | 64 | 0 | 0 | 669 | 4 |
| BTF | BUX | BOP | Butner Medium II FCI | Butner | NC | 27509 | 1 | 979* | 4083* | 1159 | 1 | 401 | 0 | 104 | 0 | 0 | 315 | 4 |
| FLF | FLX | BOP | Florence FCI | Florence | CO | 81226 | 1 | 458* | 2309* | 1312 | 1 | 710 | 0 | 111 | 0 | 3 | 536 | 4 |
| LVN | | BOP | Leavenworth USP | Leavenworth | KS | 66048 | 2 | 190 | 2105 | 1459 | 0 | 484 | 0 | 32 | 0 | 58 | 557 | 4 |