Idaho DUR Board Meeting Minutes

Date: October 15, 2015 **Time:** 9am-1:30pm

Location: Idaho Medicaid, 3232 Elder Street, Boise, Idaho, Conference Room D-West

Moderator: Mark Turner, M.D.

Committee Member Present: Mark Turner, M.D., Matthew Hyde, Pharm.D., Paul Cady, Ph.D., Lane Deitchler, DNP, Wayne Baures, R. Ph., Perry Brown, M.D., Elaine Ladd, Pharm.D.

Others Present: Tami Eide, Pharm.D., Christopher Johnson, Pharm.D., Jane Gennrich, Pharm.D., Tammy Haugland, Mark England, Pharm.D.

AGENDA ITEMS	PRESENTER	OUTCOMES/ACTIONS
Committee Business ➢ **Call to Order**	Mark Turner, M.D.	Dr. Mark Turner, Chairman, called the meeting to order.  DUR_10_15_2015_Final.pdf
➢ **Review of Minutes from July 16, 2015**	Mark Turner, M.D.	Minutes were approved as written
➢ **Follow-up to Previous Reviews** • Multiple Dosage Forms of Aripiprazole Prescribed Concomitantly	Mark England, Pharm.D. Jane Gennrich, Pharm.D.	**Slides 2 - 13** Dr. England presented previous slides as background:

		• Usual maximum FDA approved daily dose for aripiprazole (Abilify) is 30mg.
		• Tablets available in 2, 5, 10, 15, 20, and 30mg strengths
		• Discmelt tablets as 10, 15mg strengths
		• Baseline
		  ○ Paid claims for oral aripiprazole between 3/1/2015 and 5/31/2015 were evaluated.
		  ○ 74 patients identified with two or more fills for two or more capsule strengths
		  ▪ 62 (84%) on ≤ 30mg daily
		  ▪ 12 (16%) on > 30mg daily
		Copy of DUR paragraph of letter sent to prescribers of 10 patients on 7/7/2015 was shown. Of the 10 letters sent only 5 were returned and no comments were given.
		
		Questions/Comments
		No comments or questions were brought forward.

• **Ongoing review** ○ Hepatitis C Update	Chris Johnson, Pharm.D.	**Slides 15 - 30** Dr. Johnson presented Hepatitis-C Outcomes Report which looked at a review of requests for Hepatitis C agents from 1/1/2015 to 9/30/2015. Demographics: • Total 70 Males: • Mean age 51 y/o (Range: 21 to 67) • Total 64 Females: • Mean age 49 y/o (Range: 18-70) Requests: • 140 total reviewed ○ 50 approved ○ 84 denied ○ 6 pending review (missing required information) Approved Requests • 37 Harvoni • 13 Sovaldi • 0 Viekira Genotype • 38 Type 1 • 4 Type 2 • 8 Type 3 • 0 Type 4 Liver fibrosis Staging • 32 F3 • 18 F4 Cirrhosis (explained in detail) • 37 Hx of Cirrhosis • 13 No Cirrhosis Denied Requests (as time has went on and criteria has been out, requests for those that had previously

		been denied have gone down) • 61 did not meet criteria • 10 active substance abuse • 13 incomplete request Drug • 53 Harvoni • 22 Sovaldi • 4 Viekira Pak (seeing more requests than previously, may be due to their Patient Assistance Program) Liver Fibrosis Staging . Noted that serologic testing is becoming more common than biopsies. • 26 F0 • 29 F1 • 12 F2 • 9 F3 • 6 F4 • 2 Not reported Genotype • 63 Type 1 • 9 Type 2 • 11 Type 3 • 1 Type 4 SVR 1/2014 to Current n=30 • 24 SVR 12 achieved • 10 SVR 24 achieved • 3 SVR 12 not achieved • 2 Patients died before SVR 12 • 1 Treatment failure (Genotype 3) Recently approved Medications reviewed • Daklinza and Technivie

○ Buprenorphine and Benzodiazepine DUR	Mark England, Pharm.D. Jane Gennrich, Pharm.D	**Questions/Comments** Have there been repeat requests for ones previously denied? Yes and majority have been same fibrosis stage so denied kept in place. One patient went from an F0 to an F3 in a short time period and the request was approved. How does Idaho compare to other States in terms of criteria review? Varies across State to State with some approving all and others having stricter criteria. Idaho tends to be similar to the majority of other states when comparisons have been done. **Slides 31 – 39** Suboxone Package Insert • Buprenorphine in combination with benzodiazepines or other CNS depressants including alcohol has been associated with significant respiratory depression and death. • Patients should be warned of the potential of self-administration of benzodiazepines or other depressants while under treatment with Suboxone. Of the 241 participants receiving buprenorphine, 57 were also receiving a benzodiazepine. • 44 had one benzo • 12 had two benzos • 1 had 3 benzos 55 DUR survey letters were sent to prescribers on 7/2/2015 for identified participants. 15 letters were returned and 4 had written responses which were reviewed.

○ Patients Receiving More Than 1 Long-Acting Opioid Analgesic	Tami Eide, Pharm.D.	**Questions/Comments**
		Could these recipients be referred to the Lock-In Program? Often these are written by the same prescriber so not sure if lock in would be beneficial.
		
		Can the Board of Pharmacy reports be queried for Medicaid Recipients? State is currently working with the BOP to find out what is possible.
		
		DUR Board has requested that an Idaho BOP representative come to the next DUR to present on the PDMP.
		
		Slides 40 – 64
		
		Dr. Eide presented her findings from this review:
		
		Chronic Pain Management Standard Practice
		• Long-acting opioid for primary throughout the day pain relief
		• Short-acting opioid as needed for acute/breakthrough pain
		• Duplication of long-acting may result in overdose and/or increase in side-effects
		Patient Medication Profile Review
		• 7 Patients identified who were receiving > 1 Long-Acting Opioid for > 2 months
		• Letters sent on July 27 to prescribers for those 7 patients
		• Included
		  • Patient Medication Profile
		  • Prescription Monitoring Program (PMP) Report

○ Foster Children – High Utilizers	Tami Eide, Pharm.D.	Letter Key Points
		• Part of an overall opioid analgesic prescribing improvement project
		• November 1, 2015 a hard edit for therapeutic duplication would be put into effect
		  • Need to consolidate to one agent OR
		  • Request prior authorization with justification and plan
		• Described future initiatives
		  • > 1 short-acting
		  • Disallowing long-term short acting without long acting
		  • MED < or = to 120 mg/day
		Dr. Eide then presented an in-depth review of the seven patients with their diagnoses, prescription fills and responses from the prescribers.
		
		Questions/Comments
		No questions or comments from the Board
		
		Slide 65
		
		Dr. Eide referred Board to a provided handout and explained that letters were recently sent out to prescribers and responses will be brought back to the next Board Meeting.

➢ **Current Interventions/Outcomes Studies** ○ Multiple Dosage Forms of Oral Paliperidone (Invega) Prescribed Concomitantly	Jane Gennrich, Pharm.D.	**Slides 67 - 73** Dr. Gennrich shared results of her review on multiple dosage forms of paliperidone prescribed

		concomitantly.
		• Tablets available in 1.5, 3, 6, and 9mg strengths
		• Designed for once daily dosing
		• Maximum FDA approved daily dose for paliperidone (Invega) is 12mg.
		• Baseline
		  ○ Paid claims for oral aripiprazole between 7/1/2015 and 9/30/2015 were evaluated.
		  ○ 210 patients identified with at least one paid claim
		  ○ 15 patients identified with two or more tablet strengths prescribed concomitantly
		• Monthly WAC drug cost for 30 day supply of 12mg/day dose
		  • Using two 6mg tablets: $1835
		  • Using one 3mg plus one 9mg tablet: $2125
		• Plus have two monthly dispensing fees when using two different tablet strengths.
		• Annual cost savings with using two 6mg tablets rather than one 3mg and one 9mg tablet (assuming $11.51 dispensing fee): $3616 (per patient)
		• For 1.5mg plus 6mg tablets (7.5mg daily dose)
		  • Cost savings $5239 annually if round dose up to 9mg tablet once daily
		• For 3mg plus 6mg tablet daily (9mg daily dose)
		  • Cost savings $5239 annually if use one 9mg tablet instead

		• For 6mg plus 9mg tablets (15mg daily) – • Will need therapeutic justification for exceeding maximum FDA approved daily dose of 12mg **Questions/Comments** Letters will be sent out and results will be presented at the next DUR meeting.

○ Medications Billed as Medical Claims	Jane Gennrich, Pharm.D.	**Slides 74- 85**
		
		• Since 2012, the Pharmacy Unit has reviewed 878 medical claim codes (primarily J-codes) that are medications administered as physician administered drugs
		• Evaluated number and cost of paid claims as well as potential for inappropriate use
		• 106 medical claim codes for medications currently require prior authorization
		• High utilization and low cost – will not require prior authorization
		  • Examples: injectable morphine, Synvisc (knee injections), injectable methotrexate (first line therapy for many types of cancer)
		• Low utilization and high cost – will likely require prior authorization
		  • Examples: botulinumtoxin, Xgeva, Vitrasert (ganciclovir intravitreal insert)
		• Some medications can be billed as EITHER a prescription drug claim or as a medical claim
		  • e.g. Synagis, immune globulins
		• If the medication requires prior authorization if billed as a prescription drug claim, it will also

		require prior authorization if billed as a medical claim
		• Now receive quarterly list of any new medications that can be billed as physician administered drugs (PAD) to determine if prior authorization should be required.
		• Examples of Denials
		  • Botulinumtoxin for off-label indications: fecal incontinence, gastroparesis, excessive salivation.
		  • Supprelin implant for precocious puberty (alternative more cost effective therapy had not been tried)
		• Pharmacists are reviewing these medications
		  • Even though claims are actually billed as medical claims
		  • Medication expertise
		  • Experience in reviewing requests for medical necessity as well as knowledge of alternative therapies
		  • Started to track time spent on this task weekly as well as cost savings.
		
		Questions/Comments
		No questions or comments from the Board

○ Second-Generation Antipsychotic Use in Children	Tami Eide, Pharm.D.	**Slides 86 - 111** Dr. Eide presented her findings from this review: In March 2015 the Office of the Inspector General released a report on Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children and their Quality-of-Care Concerns

		• Premise of Study
		  • Drug class is widely used to treat children enrolled in Medicaid
		  • Second Generation Antipsychotics (SGA) have serious side effects
		  • Little clinical research has been done
		• States Included in Study
		  • California, Florida, Illinois, New York, Texas
		These states represented 39% of the total Medicaid payments for SGAs in 2011
		• Methodology
		  • Board-certified child and adolescent psychiatrists reviewed medical records related to the sampled claims
		  • Objectives
		  • Quality of Care Concerns
		  • Non-medically Accepted Indications
		  • Prescribed for conditions described in black box warning
		• Results were presented and the review was based totally on medical record documentation that was received.
		• Qualifying Statement from the report:
		  • " It is difficult to conduct the clinical trials needed to obtain FDA approval or compendia support for pediatric uses of drugs"
		• Recommendations to CMS by the OIG
		  • Work with States to:
		  • Perform utilization reviews of SGAs prescribed to children
		  • Conduct periodic reviews of

		medical records associated with claims for SGAs prescribed to children • Consider other methods of enhanced oversight of SGAs prescribed to children, such as implementing peer review programs • Dr. Eide presented Idaho Specific Data in regards to Medication Utilization broken down by drug and age: • Data from March through August 2015 • 5,688 Unique Recipients • 17,322 Claims • $4,862,907 Expenditures • Next Steps: • OIG Suggestions • Utilization Review Focus • Age • Duration of Treatment • Overall Drug Regimens • Periodic Reviews of Medical Records Associated with Claims for SGAS prescribed to children Focus • Clear prescribing rationale • Proper monitoring • Dosages properly adjusted • Other Methods of Enhanced Oversight • Peer Review Programs • HEDIS measures voluntary reporting • Idaho Specific • Focus on ages 0 to 6 • Quetiapine low doses – possibly

		used for sleep • Partner with Optum **Questions/Comments** No questions or comments from the Board

➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	Dr. England presented following topics:
		• Top 150 Utilizers of Opioids
		  • Comparison to previous years
		  • Evaluate for the following criteria
		  • > 1 Long-Acting Opioid for > 2 months
		  • > 1 Short-Acting Opioid for > 2 months
		  • Short-Acting Opioid > 2 months with no Long-acting Opioid
		  • Short-Acting Opioid > 2 months with Short-Acting > 50% of Total Opioid dose
		  • Total morphine equivalent daily dose (MED) > 120 mg
		• Opioid and benzodiazepine concomitant use
		• Atypical Antipsychotics in children ≤ 6 years of age
		• New CF Drugs – Kalydeco and Orkambi
		  • Review overall cost of therapy (including all medications as well as hospitalizations and outpatient care costs) for CF patients now on Kalydeco or Orkambi
		  • Since 8/1/2015 we have 6 paid claims for 4 recipients for Orkambi and 3 paid claim for 2 recipients for Kalydeco totaling $166,795
		
		Questions/Comments

		• In terms of recipients paying for opioids with cash, Policy told pharmacy unit that it was too late for any submissions for a State Plan Amendment for this year, however working with Pharmacy Association to work together for a potential solution. • Medicaid will pay for Naloxone for Medicaid recipients. • Dr. Perry Brown gave an overview of his experiences with these new CF agents and how they work and whom they are best prescribed for use.
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **DUR Newsletter**	Mark England, Pharm.D.	Clinical Alerts and Quarterly Trends provided
➢ **Medicaid Update**	Tami Eide, Pharm.D.	Dr. Eide explained how the appeal process has changed and the increased workload for her unit.
➢ **Adjourn, 1:30pm**	Mark Turner, M.D.	

Next Meeting: January 21, 2016