Idaho DUR Board Meeting Minutes

Date: January 21, 2016 **Time:** 9am-1:30pm

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

Moderator: Mark Turner, M.D.

Committee Members Present: Mark Turner, M.D., Matthew Hyde, Pharm.D. Paul Cady, Ph.D., Lane Deitchler, DNP, Perry Brown, M.D.

Others Present: Tami Eide, Pharm.D., Christopher Johnson, Pharm.D., Jane Gennrich, Pharm.D., Mark England, Pharm.D., Jeanie Armstrong

AGENDA ITEMS	PRESENTER	OUTCOMES/ACTIONS
Committee Business ➢ **Call to Order**	Mark Turner, M.D.	Dr. Mark Turner, Chairman, called the meeting to order.
➢ **Review of Minutes from Oct 15, 2015**	Mark Turner, M.D.	Minutes were approved as written
➢ **Follow-up to Previous Reviews** • Receiving > 1 Long-Acting Opioid	Tami Eide, Pharm.D.	**Slides 3-15** Dr. Eide presented slides on follow up of Patients Receiving More Than 1 Long-Acting Opioid Analgesic. Chronic pain management standard practice

		includes:
		
		• 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
		Letter Key Points
		• Part of an overall opioid analgesic prescribing improvement project
		• Advisement that 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
		  • Morphine Equivalent Dose (MED) < or = to 120 mg/day

		Dr. Eide reviewed case studies of the seven (7) identified who were receiving > 1 Long-Acting Opioid for > 2 months
		
		Summary
		Action:
		• PA submitted for Second LAO 2 (0 approval)
		• Second LAO discontinued 2
		• Weaning off of 2nd LAO 1
		• No Action 2
		Change in MED:
		• Decrease in Daily MED 4
		• 120 daily Med
		  ○ prior = 6
		  ○ post = 6
		Next Steps
		• Therapeutic Duplication Edit
		• **Description**: Hard stop with 2nd LAO within current LAO days' supply denied (i.e. no overlap)
		• **Implementation**: within the next 30 days

• Multiple dosage forms of aripiprazole prescribed concomitantly	Mark England, Pharm.D.	**Slides 16 – 26** Dr. England shared results of study on Multiple Dosage Forms of Aripiprazole Prescribed Concomitantly • Usual maximum FDA approved daily dose for aripiprazole (Abilify) is 30mg. • Aripiprazole 3/1/15 – 5/31/15 5554 claims 2252 unique recipients $4,540,782 Baseline of study • 74 patients identified with two or more fills for two or more tablet strengths ○ 62 (84%) on ≤ 30mg daily ○ 12 (16%) on > 30mg daily Plan: • A letter along with a Qty Override Prior Authorization Form and Member Rx Profile was sent to prescribers of 10 members on 7/7/2015., ○ Of the ten letters that went out only five were returned; however, no additional comments were written on the response form.

• Multiple dosage forms of oral paliperidone (Invega) prescribed concomitantly	Mark England, Pharm.D.	**Slides 27 – 35**
		
		Dr. England reviewed the study of Multiple Dosage Forms of Oral Paliperidone (Invega) Prescribed Concomitantly.
		
		• Invega is designed for once daily dosing (extended release formulation).
		• Maximum FDA approved daily dose for paliperidone (Invega) is 12mg.
		• Generics just became available September 2015
		  • So far three manufacturers of generic: Actavis, Mylan, Patriot
		
		Additional visual data was presented via graphs, tables, and pie charts referencing above drugs
		• 210 patients identified with at least one paid claim for Invega (7/1/15-9/3/2015)
		  ○ 195 had only one tablet strength
		  ○ 15 received two tablet strengths
		  ▪ 2 had a 1.5mg+6mg
		  ▪ 2 had a 3mg+6mg
		  ▪ 10 had a 3mg+9mg
		  ▪ 1 had a 6mg+9mg
		
		Potential annual cost savings using a single strength was estimated. Going from two to one dispensing fees per month was estimated assuming the lowest dispensing fee of $ 11.51.
		
		• Using two 6mg tablets rather than one 3mg and one 9mg tablet : $3616

		• For 1.5mg plus 6mg tablets (7.5mg daily dose) 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

• Buprenorphine and Benzodiazepine in Combination	Jane Gennrich, Pharm.D.	**Slides 36 - 44** Dr. Gennrich first updated the Board on buprenorphine utilization. • Total participants on oral buprenorphine increased by 65 participants from 2/1/13 to 11/30/15 • Participants who paid cash for an opioid while on oral buprenorphine increased from 26-40 for the same time period. Suboxone Package Insert was reviewed; • 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. Additional visual data was presented via graphs,

		tables, and pie charts of patients who were on buprenorphine who were also receiving benzodiazepines concurrently. .
		• Timeline 3/1/15-5/31/15
		• Buprenorphine AND benzos = 57 patients
		  ○ One Benzo =44
		  ○ Two Benzos = 12
		  ○ Three Benzos = 1
		• Buprenorphine (no benzos) = 184 patients
		
		DUR letter was sent out 7/2/15 to prescribers.
		
		55 letters were sent out to prescribers and a total of 31 came back as of 1/12/2016.
		
		Written responses were received; refer to slides for specific details.

➢ **Idaho Prescription Monitoring Program**	Alex J. Adams, PharmD, MPH	Guest speaker Alex J. Adams, PharmD, MPH, Executive Director from Idaho State Board of Pharmacy presented on the Idaho Prescription Monitoring Program (PMP). Dr. Adams reviewed the history and purpose of the Prescription Monitoring Program which was established in 1997. He reviewed the part of Idaho regulations which allows Idaho Medicaid pharmacists to use the PMP for Medicaid patients. He noted that registered users of the PMP have increased 263% since July 1, 2014 due to change in requirements for controlled substance registration. Not all registered users are accessing the system and the change in the monthly requests has only grown 53% for the same time period. Although 99% of prescribers are enrolled in the PMP, only 60% of

		pharmacists are. The average number of weekly requests is highest for pharmacists and second highest for physicians. He also reviewed unsolicited reports sent to prescribers by the Board of Pharmacy which includes reports on patients receiving controlled substances form five (5) or more different prescribers per month. He discussed emerging CMS Quality Measures for Opioid Use which includes high dosage and/or multiple providers. The Board discussed different ways the Board of Pharmacy and the Medicaid Pharmacy Program might collaborate including receipt of specific reports sent directly to Medicaid.
➢ **Ongoing review** • Narcotic Prescribing Improvement Project o Top 150 Utilizers	Tami Eide, Pharm.D.	**Slides 46 - 64** Dr. Eide presented the Narcotic Prescribing Improvement Project Top 150 Utilizers Report which looked at narcotic patterns of use in chronic non-malignant pain for Idaho Medicaid participants Profile Review • Generated profiles for the top 150 recipients by total narcotic claim count from the recipients who had at least one narcotic claim in each of the 24 months of the period ending August 31, 2015 • Time Period: March 1, 2015 through August 31, 2015 • Last study period: October 1, 2012 through

		March 31, 2013 • All profiles were hand reviewed by Idaho Medicaid Pharmacists • 7 patients had cancer diagnoses, but were kept in evaluation as all but one patient also had chronic non-malignant pain unrelated to cancer diagnosis Review Focus • Demographics - age and gender • Health and Welfare regional variation • Pain Related Diagnoses • Drug and/or alcohol abuse history • Lock-in Status • Opioids with cash payments • Number of Prescribers • Average Daily Morphine Equivalent Dose over 6 months (MED) Focus Criteria • Using more than one long-acting opioid concurrently for greater than 2 months • Using more than one short-acting opioid concurrently for greater than 2 months • Use of short-acting opioids only without long-acting opioid for greater than 2 months • Short-acting opioid total daily morphine equivalents > 50% of total daily morphine equivalents • Daily morphine equivalents > 120 mg • Concurrent chronic benzodiazepine use • If concurrent benzodiazepine use – whether prescribed by same or different prescriber of opioids

Results

	2015	%	2012
Cancer Diagnosis	7	5%	8
Abuse Diagnosis	41	27%	66
Lock In	5	3%	5
> 1 Long-Acting	9	6%	not done
> 1 Short-Acting	48	32%	not done
Short-acting without Long-acting	35	23%	not done
Short Acting> 50% total Daily MED	35	23%	not done
MED > 120	91	61%	not done
Concurrent Benzodiazepine	82	55%	not done
Benzo same prescriber as Opioids	54	66%	not done
Opioids Paid Outside of Medicaid (Cash)	51	34%	34

		Patients also in 2012 Study 45 30% NA
		
		Number of focus criteria met:
		• 6 met - 0
		• 5 met - 5
		• 4 met - 14
		• 3 met - 33
		• 2 met - 41
		• 1 met - 43
		• None met - 14
		
		Demographics
		• Age Range 23-69
		  • 20-29 years 8
		  • 30-39 years 23
		  • 40-49 years 57
		  • 60+ years 30
		• Gender
		  • Male 38 (25%)
		  • Female 112 (75%)
		
		Additional visual data was presented via graphs and tables.
		• Number of Unique Prescribers
		• Regional Variations
		• Diagnosis/Indications
		• Daily Morphine equivalents
		
		Dr. Eide did a case study overview of eight (8) patients with > 1000 daily morphine equivalents.
		
		• Patient 38 1110 MED (changed to Medicare Sept. 15)

• Methadone Utilization	Chris Johnson, Pharm.D.	• Patient 98 1173 MED • Patient 119 1279 MED • Patient 141 1470 MED • Patient 110 1589 MED • Patient 61 1611 MED • Patient 96 2082 MED • Patient 45 2244 MED Refer to slides for specifics. She also reviewed a case of a patient paying cash for additional narcotics. **Slides 65 - 95** Dr. Chris Johnson presented a review of Idaho Medicaid Methadone Utilization from 4th Quarter of 2015. Dr. Johnson reviewed the Centers for Disease Control and Prevention report of the growing public health concern of opioid related deaths in the USA due to drug overdose. He noted that methadone was responsible for 1/3 of opioid related deaths but accounts for only 2% of opioid prescriptions. Methadone utilization for Idaho Medicaid from 4th quarter of 2015 totaled 226 unique prescribers for 306 unique patients and 927 total claims. A majority of patients were prescribed methadone for each month of the reporting quarter which suggests chronic use. Methadone 10mg tablets were prescribed more often than 5mg tablets and 30% of patients were taking greater than 40mg of

		methadone a day (320 morphine equivalents). Dr. Johnson presented a table reporting the non-linear relationship of methadone conversion to morphine equivalents and reported how dose increases in methadone have dramatic effects on total daily morphine equivalents. Dr. Johnson concluded with the "Next steps" to limit methadone use by informing prescribers of changing methadone to non-preferred status and initiating prior authorization for methadone.
• Hepatitis C Update	Chris Johnson, Pharm.D.	**Slides 80-95** Dr. Chris Johnson presented Idaho Medicaid Hepatitis-C requests for the 4th Quarter of 2015. Dr. Johnson reported that 41 requests were submitted for review and 15 of these requests were approved. Twenty requests were denied for not meeting current clinical criteria and 6 requests were pending for incomplete submission. Harvoni was approved for 12 patients, Sovaldi/Daklinza was approved for 2 patients, and Sovaldi was approved for 1 patient. A majority of the patients were approved for Genotype 1 (n=12). The others included genotype 2 (n=1) and genotype 3 (n=2). Patients approved for treatment had liver staging of

		F3 (n=7) and F4 (n=13) with 60% reporting no liver cirrhosis and 40% reporting cirrhosis. Dr. Johnson reported on 20 requests that were denied for not meeting criteria. Nine requests for Harvoni were denied, Sovaldi (n=4) and Viekira Pak (n=7). A majority of genotypes that were denied was for genotype 1 (n=16). Other denials were genotype 2 (n=2), and genotype 3 (n=2). Denied requests for submitted liver fibrosis was F0-F1 (n=14) and F2 (n=5). One F4 patient was denied because patient was Medicare eligible. The 4th Quarter total cost for approved agents was $1,525,307.00. Dr. Johnson concluded his presentation with an update on newer agents being reviewed for FDA approval in 2016. The newer agents have a broader indication for most genotypes and shorter duration of therapy.
➢ **Current Interventions/Outcomes Studies** • Albuterol MDI	Jane Gennrich, Pharm.D.	**Slides 96 - 108** Dr. Gennrich shared results of the Albuterol MDI study. Current guidelines state that high usage of short-acting beta$_2$-agonists is a risk factor for asthma exacerbations; furthermore excessive usage (more than 200 doses/month) is a risk factor for asthma-related death.

		Profiles were reviewed for patients who filled ≥ 9 albuterol MDI's over the six month time period from May 1 – Oct 31, 2015.
		• Total of 109 patients identified.
		• Majority of patients were on ProAir (preferred bronchodilator) which contains 200 actuations/canister. Some patients were on Proventil (preferred), Ventolin (non-preferred), and Xopenex (non-preferred) which all also contain 200 actuations per canister.
		
		Additional visual data was presented via graphs, tables, and pie charts.
		• Patients on ≥ 9 inhalers / 6months = 109 (1%)
		• Patients on < 9 inhalers / 6months = 15,546 (99%)
		• Patient Age
		  • < 18 years- 26
		  • 18-29 - 15
		  • 30-49 - 32
		  • 50-64 - 32
		  • ≥65 - 4
		• Diagnosis
		  ▪ Asthma - 83
		  ▪ COPD - 26
		
		Asthma (83 patients total)
		• no inhaled steroid 39
		• 1-3 fills in 6 months 19
		• ≥4 fills in 6 months 25

		For the 39 asthma patients who were not on an inhaled steroid • 5 were on montelukast • 8 were also on nebulized albuterol It was recommended to send an interventional letter to prescriber of patients who are not receiving an inhaled steroid or less than four (4) fills of an inhaled steroid in the last six (6) months and/or receiving excessive fills of albuterol. It was suggested that the letter include information on spacers and how to get them paid for by Medicaid. It was suggested that the pharmacy program consider sending a similar letter to dispensing pharmacies.
➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	Dr. England presented the following potential topics: • Opioid and benzodiazepine concomitant use • Atypical Antipsychotics in children ≤ 6 years of age • New CF Drugs – Kalydeco and Orkambi o Review overall cost of therapy (including all medications as well as hospitalizations and outpatient care costs) for CF patients now on Kalydeco or Orkambi o Since 8/1/2015 we have 32 paid claims for 11 recipients for Orkambi and 7 paid claims for 3 recipients for Kalydeco totaling $647,284 • Multiple dosage forms of quetiapine prescribed concomitantly To include o Immediate release (IR) and extended release (ER)

		○ Patients receiving both IR and ER ○ Review of patients taking low doses using 25 and 50mg tab strengths
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **IDHW Program Integrity on Pharmacy Fraud and Abuse**	Lori Stiles	Lori Stiles from the IDHW Program Integrity Unit presented an overview of her department activities on pharmacy related fraud and abuse. Currently, their initial review consists of clients, providers, NPI's, Rx, Rx per provider, ER visit, number of pharmacies. There was discussion on how the pharmacy program and the program integrity unit might partner. Including the DEA in this partnership was also discussed. Ms. Stiles gave information for the pharmacy program to contact Fraud and Abuse. Fraud and Abuse Hotline: 208-334-5754 or 211-CARE.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	Dr. Eide had no updates
➢ **Adjourn, 1:45pm**	Mark Turner, M.D.	

Next Meeting: April 14, 2016