Idaho DUR Board Meeting Minutes

Date: July 21, 2016 **Time:** 9am-12:30pm

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., 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[☆]

[☆]Magellan Rx Management

AGENDA ITEMS	PRESENTER	OUTCOMES/ACTIONS
Committee Business ➢ **Call to Order**	Mark Turner, M.D.	Dr. Mark Turner, Chairman, called the meeting to order. DUR_7_21_2016_Final.pdf
➢ **Review of Minutes from April 14, 2016**	Mark Turner, M.D.	Minutes were approved as written.
➢ **Follow-up to Previous Reviews** • Buprenorphine and Benzodiazepine DUR	Jane Gennrich, Pharm.D.	**Slides 2 - 10**

		Dr. Gennrich shared results of her review on buprenorphine and benzodiazepine concurrent use. A payment block went in to effect 1/6/16 requiring prior authorization for payment for either buprenorphine or benzodiazepine with overlapping days of service. Letters were sent out ahead of time to affected prescribers. Additional visual data was presented via graphs and tables. • Total number of participants on oral buprenorphine remained consistent this past quarter while those paying cash for an opioid slightly decreased again this quarter. • Patients on concomitant benzodiazepines while on buprenorphine decreased slightly from 59 to 55. • Patients paying cash for opioids AND also on concomitant benzodiazepines while on buprenorphine decreased from 19 to 10. • Most buprenorphine and benzodiazepine concomitant use was prescribed by the same prescriber. Clonazepam has the greatest use of the benzodiazepines in these patients and appears to be mainly used for Generalized Anxiety Disorder.
➢ **Ongoing Reviews** • Hepatitis C Update	Chris Johnson, Pharm.D.	**Slides 11 - 25**

		Dr. Johnson presented the quarterly Hepatitis-C Outcomes Report for 2nd Quarter 2016 (4/1/2016-6/30/2016) A total of 50 requests for treatment were submitted and 17 were approved, 28 denied, and 5 were pending, waiting for additional information for review to be submitted. A total of 14 males and 3 females were approved for which 9 patients were approved for Harvoni, 5 patients for Sovaldi/Daklinza, and 3 patients for Sovaldi. The most prevalent genotype of approved patients was Genotype-1 (9 patients). Genotype-2 (4 patients) and Genotype-3 (4 patients) made up the remainder of approved patients. For approved requests, there were 9 patients with F3 staging, 7 with F4 and 1 patient who had primary insurance and one treatment course remaining who had F1 staging. Patients with documented cirrhosis accounted for 71% of the approved patients. A total of 28 patients were denied for not meeting criteria. Dr. Johnson reported 12 males and 16 females did not meet criteria for approval. The hepatitis-C agents denied were Harvoni (15), Sovaldi (7), Viekira Pak (3), and Sovaldi/Daklinza (3). Liver fibrosis data submitted for denied patients for the following stages were reported: F0 staging (5), F1 staging (15), F2 staging (4), F3 staging (1) F4 staging (2) and one denied request did not report liver staging. The requests were denied for not meeting disease staging criteria (20), active substance abuse (3), Medicare coverage (1), and incomplete follow-

		up (4). Total costs for the 2nd quarter reported $1,900,849.64 for Hepatitis C agents. Dr. Johnson presented information on a new product, Epclusa ®(sofosbuvir/velpatasvir) • Approved for the treatment of genotypes 1-6 HCV infections. • Allows 12 weeks treatment without ribavirin for genotypes 2 and 3. • Patients with decompensated cirrhosis can be treated with a 12 week course in combination with ribavirin.
• Foster Children and Psychotropic Drugs	Tami Eide, Pharm.D.	**Slides 26 - 43** Dr. Eide gave a brief overview of the GAO study that was published in 2011 and provided Idaho comparison to the original 5 State's data. Dr. Eide then provided the focus review from 2015 for the Idaho Medicaid Population. The review consisted of data and graphs comparing Foster Children and Non-Foster Children and the various drug classes as well as breakdowns of ages and gender. Dr. Eide also discussed the claims related data as it pertained to prescriber types and regional variations of these prescriber types. Dr. Eide then finished by describing the next steps in the plan for this topic.

		• Case evaluation of foster children receiving more than 50 claims for psychotropic drugs during 2015 (starting with Top 10)
		• Cross agency coordination
		  • Family and Children Services
		  • Medicaid
		  • Optum (Mental Services contractor)

• CDC Guideline for Prescribing Opioids for Chronic Pain	Tami Eide, Pharm.D.	**Slides 44 - 66**
		
		Dr. Eide presented the CDC Guideline for Prescribing Opioids for Chronic Pain from the MMWR March 15, 2016.
		
		The presentation included:
		• Guideline Goals
		• Guideline Groupings for Consideration
		• Chronic Pain Definition
		• Determining when to initiate or continue opioids for chronic pain
		• Opioid selection, dosage, duration, follow-up, and discontinuation
		• Assessing risk and addressing harms of opioid use
		• Other agency plans
		  ○ FDA
		  ○ NIH Strategy
		  ○ CMS best practices for addressing prescription opioid overdoses, misuse, and addiction.

• Idaho Medicaid Activities for Improving	Tami Eide, Pharm.D.	**Slides 67 - 83**

Opioid Prescribing		Dr. Eide Provided a detailed explanation of Idaho Medicaid Activities for Improving Opioid Prescribing.
		• Began with overview of what can be done moving forward with new recipients as well as those who are currently being treated with opioids.
		
		Completed Activities:
		• Long-Acting Opioids
		  ○ Hard edit not allowing more than one long-acting opioid
		  ○ Manual prior authorization of OxyContin and fentanyl transdermal
		  ○ Methadone moved to Non-Preferred status
		• Buprenorphine
		  ○ Concurrent opioids not allowed
		  ○ Quarterly PMP check on cash payment of opioids – buprenorphine payment stopped
		  ○ Restricting all buprenorphine without naloxone prescriptions to pregnant women only
		  ○ Blocking concurrent buprenorphine use with a benzodiazepine
		• Top 150 recipients by total narcotic claim count during the last 2 years reviewed in conjunction with PMP
		  ○ Diagnosis
		  ○ Daily morphine equivalents
		  ○ Therapeutic duplication
		  ○ Concurrent benzodiazepines
		  ○ Drug and alcohol abuse history

		○ Regional variation Other Activities: • Oxycodone IR moved to non-preferred • Carisoprodol denies for any patient concurrently taking a opioid In Process: • Methadone prior authorization requirement for newly started patients • Interventional letter to prescribers of Top 150 Utilizers • Working with Board of Pharmacy on cash paying patients • Working with Program Integrity on cash payments, provider issues, possible DEA referrals • DUR: Patients using benzodiazepines in combination with opioids • Placing electronic morphine equivalent calculator on website • Redesign of “Lock-In” (patient review and restriction) Program Future Plans: • Methadone current patients. Encouraging prescribers to switch to a different opioid, dose tapered to < 40 mg daily and re-authorization requirements. • Daily Morphine Equivalents. Stepwise approach to reduce to 120 daily morphine equivalents. • Hard edit on benzo/opioid combinations • Block two or more immediate release

		concomitant opioids
		• Duration limits
		  ○ Acute pain
		  ○ Chronic pain
		• Create a list of patients with known opioid overdoses (at risk for future adverse effects and/or abuse)
		• Fentanyl, methadone and oxycodone to require a new prior authorization every 90 days
		• Prior Authorization Requirements
		  ○ Require prescribers to calculate morphine equivalents of all drugs and enter on PA form.
		  ○ Require prescribers to validate that they have checked the PMP before prescribing the prior authorized opioid
		  ○ Indicate that they have checked for non-pain primary diagnosis (mental health with pain as symptom)
		  ○ Have a check list of non-drug options to ensure physician has tried and/or included them in their evaluation
		• Education
		  ○ Tapering
		  ○ Hyperanalgesia
		  ○ Non-drug therapy alternatives
		  ○ Pain contracts
		  ○ CDC Guidelines in general

• Methadone	Chris Johnson, Pharm.D.	**Slides 84 - 94**

		Dr. Johnson presented background data on methadone nationally as well as comparative utilization data for Idaho Medicaid from 4th Qtr 2015 to 2nd Qtr 2016. Total claims, unique recipients, and unique prescribers all decreased. Percentage of recipients on greater than 40mg/day remained the same. In conclusion, methadone utilization has decreased, a prior authorization process was implemented, notification letters to providers of methadone criteria were sent out, and it was pointed out that CMS and media attention to opioid prescribing has greatly increased which may also have had an effect on prescribing patterns.
• Antipsychotic Drug Use in Children Affinity Group	Tami Eide, Pharm.D.	**Slides 95 - 108** Dr. Eide reviewed as background the OIG Report from March 2015 on Quality-of Care Concerns on Second Generation Antipsychotics in Children. Dr. Eide then presented on the CMS Antipsychotic Drug Use in Children Affinity Group in which Idaho Medicaid is a participant. The goals of this group are to: • Provide a forum to share strategies, successes and challenges to improve the quality of care for children prescribed antipsychotic drugs • Identify a variety of methods States can use

		to assess Second Generation Antipsychotic (SGA) drug utilization • Improve communication and collaboration between States and stakeholder partners to support enhanced review of SGA drugs • Encourage cooperative Focus Studies and Performance Improvement Projects between States and their External Quality Review Organizations (EQROs) and managed care organizations Idaho's focus in this Group is going to be on Second Generation Antipsychotics in Children < 6 years old. Dr. Eide covered the Idaho Medicaid Driver Diagram which included all the stakeholders and the stakeholder's Goals, Measures and/or Data, and Levers of Influence.
➢ **Current Interventions/Outcomes Studies** • Skeletal Muscle Relaxants	Chris Johnson, Pharm.D.	**Slides 110 - 123** Dr. Johnson presented on Skeletal Muscle Relaxants as a follow-up DUR from a previous meeting. Dr. Johnson went over the common uses for these agents and how they are classified as either antispasmodic, antispasticity or both. He reviewed the global use as there are no established guidelines on which agents are preferred for use. As part of the follow up, these areas were explored:

		1. The number of clients prescribed skeletal muscle relaxants chronically with narcotic agents and/or benzodiazepines.
		
		2. Specific diagnosis for chronic treatment with skeletal muscle relaxants – spasticity vs chronic back pain/muscle spasm.
		
		Charts and graphs were used to discuss 4,615 unique patients prescribed a skeletal muscle relaxant.
		• Total of 3,406 unique patients 1st Q in 2016.
		  ○ Benzodiazepines: 2,665 claims
		  ○ Narcotic Analgesics: 10,185 claims
		  ○ Alprazolam, lorazepam and diazepam were the most common benzodiazepines used with the mean days' supply ranging from 20 to 27.
		  ○ Hydrocodone/Acetaminophen was the opioid with highest number of claims.
		  ○ Due to the volume of patients and claims it was not possible to sort out each individual patient's use of narcotics and benzodiazepines for the reporting quarter.
		
		Total 4,615 unique patients were reviewed for specific diagnosis codes. As there is currently limited human resources to process the volume of data provided this will be an ongoing project to evaluate the accuracy of processing diagnosis codes with pharmacy claims.
		
		Dr. Johnson then presented treatment

		recommendations:
		• Spasticity
		  • Evidence suggests chronic treatment is necessary.
		  • Abrupt discontinuation of baclofen, tizanidine, or dantrolene can cause severe side effects.
		• Chronic back pain/muscle spasm
		  • Limited evidence for the chronic treatment with skeletal muscle relaxants.
		  • Studies are limited as an adjunctive treatment for less than 30 days duration.
		  • It is suggested to limit the use of skeletal muscle relaxants for acute back/muscle pain to a 30 days' supply for a maximum of 3 courses of therapy annually.
		
		In conclusion, 74% of patients with an active prescription for skeletal muscle relaxants were taking a narcotic analgesic and/or benzodiazepine. The long term use of skeletal muscle relaxants for chronic pain/muscle spasm has not been established with clinical studies with the exception of the use of tizanidine, baclofen, or dantrolene for the treatment of spasticity due to brain or spinal cord injury.

• Synagis	Jane Gennrich, Pharm.D.	**Slides 124 - 145** Dr. Gennrich presented information on the 2015-2016 RSV Season.

		Background information was provided on Synagis from its approval in 1998 to present. Dr. Gennrich specifically reviewed the AAP Updated Guidance for Synagis prophylaxis from August 2014. The changes from 2012 recommendations to the 2014 recommendations were highlighted. A historical comparison was provided showing total requests received and the percentage that were denied from 2006 to 2016. It shows a significant drop in PA requests following the 2014 recommendations.
		
		Specific Data for the 2015-2016 was then presented which showed:
		• Denials for 2015-2016 (n=67)
		  • 16 Denials based on 2014 AAP Guidance
		  • 11 for gestational age between 29 weeks – 31 weeks, 6 days
		  • 5 for heart disease for second season prophylaxis
		  • 56 other denials (2012 and 2014 Guidance)
		  • 25 premature but now “too old” to need Synagis based on both 2012 and 2014 AAP Guidance
		  • 6 requested for lung disease but not requiring medical treatment within last six months
		  • 5 requested for heart disease but does not meet

		criteria
		• 10 child now ≥ 2 yrs. old
		• 5 gestational age ≥ 32 weeks
		
		Dr. Gennrich presented charts showing both medical and pharmacy paid claims and expenditures for this season.
		
		• Total number of unique patients with at least one paid claim: 100
		  • Approved prior authorization requests for 127 patients, so 79% of approved patients had at least one dose paid for by Idaho Medicaid as an outpatient
		  • For 2013-2014 RSV season, 88% of approved patients had at least one dose paid for by Idaho Medicaid as an outpatient
		  • For 2014-2015 RSV season, 85% of approved patients had at least one dose paid for by Idaho Medicaid as an outpatient
		  • Three patients had claims paid on both pharmacy and medical systems
		  • One dose each with duplicate billing by pharmacy and doctor's office,
		  • Letter sent to doctor's office informing them that claim needs to be reversed.
		
		A 3 year comparison of Synagis Prior Auth Approvals and the breakdown was shown in a chart.

		Graphs were shown highlighting start and end dates of the RSV Seasons and it was recommended to continue the same start date and to follow the same guidelines for the 2016-2017 RSV Season. The Board suggested that Synagis no longer needs to be presented as a DUR Topic unless there is a major change in the future.

• Ondansetron in < 1 year old	Jane Gennrich, Pharm.D.	**Slides 146 - 152**
		
		Dr. Gennrich presented on the use of ondansetron in < 1 Year olds. Data from the package insert was discussed.
		
		Idaho specific data was presented for claims data reviewed from 6/1/15 – 5/31/16
		• 586 claims
		• 543 unique patients
		  • Majority (93%) only filled one claim
		  • 43 filled > 1 claim
		  • 39 with 2 claims
		  • 2 with 3 claims
		  • 2 with 4 claims
		  • One patient with G-J tube and persistent feeding issues.
		  • Second patient is premature infant with vomiting diagnosis.
		Breakdown of all claims for infants < 1 year old was shown. Details were also presented on six claims

		filled for < 2 month old patients. Currently claims will pay at the pharmacy for up to one tablet daily for children < 16 years old. There were no recommendations at this time to make any changes to the parameters of ondansetron.
➢ **Study Proposals for Next Quarter** • Opioid and benzodiazepine concomitant use • Low dose quetiapine • Multiple dosage forms of quetiapine prescribed concomitantly	Mark England, Pharm.D.	**Slide 153** Dr. England presented the list of potential future topics. No other suggestions were mentioned by the DUR Board at this time.
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	**Slides 154 – 155** Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	**Slide 156** Dr. Eide discussed the CMS revisions of outpatient drug rules and reimbursement of medications.
➢ **Adjourn, 12:30pm**	Mark Turner, M.D.	

Next Meeting: October 20, 2016