Idaho DUR Board Meeting Minutes

Date: October 20, 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., Perry Brown M.D., Wayne Baures, RPh, Paul Cady, Pharm.D., Elaine Ladd, Pharm.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 July 21, 2016**	Mark Turner, M.D.	Minutes were approved as written.
➢ **DUR Annual Report - Highlights**	Tami Eide, Pharm.D.	**Slides 2 – 16** Dr. Eide presented the highlights for Federal Fiscal Year 2015 of the DUR Annual Report which she

		submitted. She gave the background information as it pertains to the Social Security Act of 1927. New this year included submission of the Top 10 PA requests by Drug Name, Top 10 PA requests by Drug Class, Top 5 Denial Reasons, Top 10 Drug Names by Amount Paid/Percent of Total spend, and Top 10 Drug Names by Claim Count/Percent of Total Claims. Dr. Eide then presented a table showing the Retrospective Educational Outreach Summary for FFY 2015. Following up on that were details of the DUR Board Activities for the year. A slide was presented showing the Generic Utilization which is a requirement for the report; however, Dr. Eide once again expressed how she feels this is not an accurate representation of drug spend as it pertains to FFS Medicaid because of the use of brand name medications when they are less expensive when considering all Federal and Supplemental Rebates for these products. Dr. Eide then showed how with Prospective and Retrospective Reviews the State of Idaho was able to cost avoid/save over 9 million dollars. Dr. Eide went on to present a slide showing interesting questions that may direct future activities of the DUR Board that came from the Annual Survey. Next was showing the Innovative Practices that Idaho performed: • Buprenorphine direct to the prescriber intervention • Pharmacist case management

		• Hepatitis C • Hemophilia • Foster Children Collaborative Practice • Oversight of physician administered drugs And the final slide presented were the Executive Summary Highlights: • Idaho Medicaid and Magellan Partnership • Internal PA Call Center • DUR Outcome Studies on PDL Impact • Lack of Legislative Restriction • Physician Administered Drugs • 18 RetroDUR Studies • Narcotic Analgesics and Psychotropics in Children Emphasis • Generic Utilization – not best measure • > 80 Drug Classes on Preferred Drug List
➢ **Ongoing Reviews**		

• Narcotic Prescribing Improvement Plan ○ Top 150 Utilizers	Tami Eide, Pharm.D.	**Slides 18 – 32** Dr. Eide presented the background information of how the Top 150 utilizers were identified and the results from this review. Intervention in Process: • Doing in batches by highest morphine equivalent dose • Re-evaluating for most recent 3 months • Intervention: Cover Letter, targeted paragraphs based on identified issues The format for this intervention will be consistent across patients and include findings, Guidelines/Evidence, and Recommendations/Action Needed. Treatment duration key points include: Greater > 1 year, evaluation for clinical meaningful improvements in both pain and function, maximizing on non-pharmacological interventions and non-opioid medications and if benefits do not outweigh harms taper to a lower dose and/or discontinue current opioid. Dr. Eide then presented opioid dosage key points and recommendations to be considered by the prescribers.

		Along with this correspondence, prescribers will also receive a copy of the PMP. The intention is that the prescriber will coordinate with other prescribers who are listed on the PMP since it will show when the member paid cash for claims outside of the Medicaid System. In the case that a profile review shows that a member is also taking benzodiazepines concurrently, it will be suggested that the prescriber also evaluates this use and weighs the benefits vs harms of this continued therapy. Dr. Eide finished by presenting her findings of the top 26 patients by total daily morphine equivalent dose. These were narrowed down to 10 which were evaluated for an intervention and what the findings showed. One final question that came from the Board was if there was a way to mine data from the PMP for cash paying customers which were currently receiving Medicaid benefits?
• Narcotic Prescribing Improvement Plan ○ Idaho Opioid Equivalent Dosing Project	Mark England, Pharm.D.	**Slides 33 – 45** Dr. England presented a new project that will be evaluated for use by the Pharmacy Unit of Idaho Medicaid. It is a solution that Magellan Rx Management has developed using Morphine Milligram Equivalents (MME) across a variety of their systems to promote safe and effective use of

		Opioids. Dr. England went into detail explaining the 5 areas of Magellan's Solution: 1. Prior Authorization 2. First Rx 3. First Trax 4. First IQ 5. Reporting This solution has the capability of being flexible to support the needs of Idaho Medicaid. It also provides support for the Idaho Medicaid Call Center in performing their daily use of the Magellan Systems. In regards to the current utilizers within the Idaho Medicaid System the following are details that were presented: • Using drug lists, MME Conversion Factors and the extrapolated chart for Methadone, as defined by another Magellan Rx Client, reports were run. • Specific to Idaho there were 34,869 non Methadone claims and 680 Methadone claims for a combined total of 35,549 Opioid claims during

		3q2016 (based on the opioids as defined for the other Magellan Rx Client) • There were 627 members who met or exceeded the daily MME of 300 during 3q2016. The Max Daily MME represented is the *highest* daily MME that each of these members, who met or exceeded 300, reached on any given day(s). The allowance for an overlapping Rx was 3 days. Any overlapping utilization of at least 4 days, therefore, results in a combined MME. One question raised by the Board was if there was a way to reach out to recipients and provide education directly to the member?
• Narcotic Prescribing Improvement Plan o Hospitalization Claims for Top 150 Narcotic Utilizers 2013-2016	Jane Gennrich, Pharm.D.	**Slides 46 – 49** Dr. Gennrich presented a review which originated from a question from the Director. • 96 of the 150 patients had at least one hospitalization. There were a total of 300 hospitalizations in the 96 patients (averaging 3.1 hospitalizations per patient). **<u>Reason for admission</u>** Note: No patient specifically had an admission for

		"constipation." The diagnosis of abdominal pain is potentially related to constipation but could be a myriad of other issues including appendicitis or cardiac issues. Plus only the primary reason for hospitalization was listed in this report. Dr. Gennrich then presented a chart depicting groupings of diagnoses from high to low for hospitalization claims. **Summary**: Only 14/300 (4.7%) of hospitalization admissions for Idaho Medicaid's top narcotic utilizers (identified by claim count) listed abdominal pain as the primary reason for the hospitalization. This diagnosis is very non-specific and does not necessarily correlate with constipation as there are many etiologies for abdominal pain.
• Narcotic Prescribing Improvement Plan ○ Methadone	Chris Johnson, Pharm.D.	**Slides 50 – 61** Dr. Johnson presented background data on methadone nationally. He then presented both the Methadone, Initial Request PA form and Methadone, Reauthorization PA form and the details in each of them. Dr. Johnson then presented comparative data for Idaho Medicaid from 4th Qtr 2015 to 3rd Qtr 2016. In conclusion, methadone utilization has decreased since incorporation of non-preferred status and prior authorization requirements. Total providers, total patients, and total claims have decreased. No

		change noted with percentage of patients on greater than 40 mg/day of methadone.
• Buprenorphine and benzodiazepine concomitant use	Jane Gennrich, Pharm.D.	**Slides 62 – 76** Dr. Gennrich presented an update on buprenorphine and benzodiazepine concomitant 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. PMP Interconnect now includes a total of 18 States including Idaho. New Federal regulations increased the limit rule to 275 buprenorphine patients per prescriber effective 8/8/2016. Physicians who have prescribed buprenorphine to 100 patients for at least one year can now apply to increase their patient limits to 275 under new federal regulations. Many commenters wrote about the eligibility and role of nurse practitioners and/or physician assistants in prescribing buprenorphine. The vast majority of these commenters suggested that nurse practitioners and physician assistants should be allowed to prescribe buprenorphine under the new regulation. Questions related to expanding eligible prescribers are outside the scope of this rulemaking; the statute limits who is eligible to prescribe buprenorphine for MAT.

		21 U.S.C. 823(g)(2) limits the practitioners eligible for waiver in this context to physicians, and, therefore, HHS is not authorized to include other types of providers in this rule. However, HHS recognizes the issues raised by commenters and the President's FY 2017 Budget proposes a buprenorphine demonstration program to allow advance practice providers to prescribe buprenorphine. This would allow HHS to begin testing other ways to improve access to buprenorphine throughout the country. Additional visual data was presented via graphs and tables. • Total number of participants on oral buprenorphine increased slightly this past quarter while those paying cash for an opioid slightly decreased again this quarter. • Patients on concomitant benzodiazepines while on buprenorphine remained the same at 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 once again had the greatest use of the benzodiazepines in these patients.
• Foster Children	Tami Eide, Pharm.D.	**Slide 77** Dr. Eide gave a verbal update on the current status

		of the cooperative meetings occurring between the State of Idaho Pharmacy Unit, State of Idaho FACS Team, Magellan Health Services, and Optum.
• Hepatitis C Update	Chris Johnson, Pharm.D.	**Slides 78 – 93** Dr. Johnson presented the quarterly Hepatitis-C Outcomes Report for 3rd Quarter 2016 (7/1/2016-9/30/2016) A total of 50 requests for treatment were submitted and 13 were approved, 32 denied, and 5 were pending, waiting for additional information for review to be submitted. A total of 9 males and 4 females were approved for which 8 patients were approved for Harvoni, 5 for Epclusa. The most prevalent genotype of approved patients was Genotype-1 (8 patients). Genotype-3 (4 patients) and Genotype-2 (1 patient) made up the remainder of approved patients. For approved requests, there were 8 patients with F3 staging and 5 with F4 staging. Patients with documented cirrhosis accounted for 77% of the approved patients. A total of 32 patients were denied for not meeting criteria. Dr. Johnson reported 19 males and 13 females did not meet criteria for approval. The hepatitis-C agents denied were Harvoni (17), Epclusa (8), Sovaldi (3) and Viekira Pak (4). Liver fibrosis data submitted for denied patients for the following stages were reported: F0 staging (8), F1 staging (14), F2 staging (4), F3 staging (2) F4 staging (3) and one denied request did not report liver staging. The

		requests were denied for not meeting disease staging criteria (26), active substance abuse (4), and incomplete follow-up (2).
		
		Total costs for the 3rd quarter reported $1,598,250 for Hepatitis C agents.
		
		Dr. Johnson presented information on 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.
		
		Current recommendations for HCV treatment Criteria:
		• Preferred agents for Genotype 1 HCV treatment:
		  • Harvoni®
		  • Viekira PAK™
		  • Viekira XR™
		• Preferred agents for Genotype 2,3 HCV treatment:
		  • Epclusa®
		• Clinical criteria changed to fibrosis score of F2 to F4.

• Second-Generation Antipsychotic Use in children < 6 years old	Tami Eide, Pharm.D.	**Slides 94 – 112** 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 results based upon the following: • Reviewed medication profiles of children that were 5 years or younger during calendar year 2015 and had at least one claim for a second generation (atypical) antipsychotic • 49 children met criteria The review looked at the Presumed Indication based on submitted medical claims data and then comparing that to a Supported Indication and evaluated the results. 27% had a supported indication, 37% had an indication but not approved age, 22% did not have an indication supported, and 14% the indication was unknown. This is also being done as part of a CMS Antipsychotic Drug Use in Children Affinity Group which: • Provides a forum to share strategies, successes and challenges to improve the quality of care for children prescribed antipsychotic drugs • Identifies a variety of methods States can use to assess Second Generation Antipsychotic (SGA) drug utilization • Improves communication and collaboration between States and stakeholder partners to support enhanced review of SGA drugs • Encourages cooperative Focus Studies and

		Performance Improvement Projects between States and their External Quality Review Organizations (EQROs) and managed care organizations Idaho's Focus: Second Generation Antipsychotics in Children < 6 Years Old • Overall Goal: Ensure that use of second generation antipsychotics in children < 6 years old is appropriate with positive outcomes. *Measurement*: Supported Indication Calendar year 2015 (baseline) = 27% Target rate: 90% • Small Group Participation: Authorization Dr. Eide provided a handout of a survey that was sent out to providers in September and included a request for most recent progress note. • Limited to those still under 6 (5 years or less) • 17 Surveys were sent out and 15 were returned. 1 not returned indicated that neither practitioner nor patient at clinic (but scripts being filled) • Prescriber Specialty, Primary Diagnosis, Non-Pharmacological Treatments Tried BEFORE Psychotherapy, Main Target Symptom(s), Previously Tried Medication Classes, Current Additional Medication Classes, Additional Non-Pharmacological

		Treatments, and Metabolic Monitoring were evaluated and presented. Next Steps to include: Evaluation of each patient for continuation, Consultation Process with Tellagen (External Quality Review Organization), and development of PA Criteria, Form and process.
➢ **Current Interventions/Outcomes Studies**		
• Opioid and benzodiazepine concomitant use	Jane Gennrich, Pharm.D.	**Slides 113 – 118** Dr. Gennrich presented on this topic. On August 31st, 2016 an FDA Drug Safety Communication: serious risks & death when combining opioids with benzodiazepines- Drug Information Update was sent out which stated: A U.S. Food and Drug Administration (FDA) review has found that the growing combined use of opioid medicines with benzodiazepines or other drugs that depress the central nervous system (CNS) has resulted in serious side effects, including slowed or difficult breathing and deaths. Opioids are used to treat pain and cough; benzodiazepines are used to treat anxiety, insomnia, and seizures. In an effort to decrease the use of opioids and benzodiazepines, or opioids and other CNS depressants, together, we are adding *Boxed Warnings*, our strongest warnings, to the drug labeling of prescription opioid pain and prescription opioid cough medicines, and

		benzodiazepines. **Health care professionals** should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. Avoid prescribing prescription opioid cough medicines for patients taking benzodiazepines or other CNS depressants, including alcohol. **Patients** taking opioids with benzodiazepines, other CNS depressant medicines, or alcohol, and caregivers of these patients, should seek medical attention immediately if they or someone they are caring for experiences symptoms of unusual dizziness or lightheadedness, extreme sleepiness, slowed or difficult breathing, or unresponsiveness. Unresponsiveness means that the person doesn't answer or react normally or you can't wake them up. Talk with your health care professional if you have questions or concerns about taking opioids or benzodiazepines (see List of Prescription Opioid Pain and Cough Medicines, and List of Benzodiazepines and Other CNS Depressants). Utilizing Magellan Rx First IQ Data and pulling for dates of 7/1/2016 – 9/30/2016 showed that there were 2,018 members, 1,503 prescribers, 302 pharmacies, 10,306 claims and $404,632.09 dollars

		spent on overlapping claims. It was determined that this would be too many members to review by the Pharmacy Unit so it was discussed if this number could be narrowed down. One suggestion was to look at those with either alcohol or substance abuse in this population if possible. Another suggestion was to look into further detail around days supply of the medications to see if that would show a pattern.
• Low dose quetiapine	Jane Gennrich, Pharm.D.	**Slides 119 – 125** Dr. Gennrich presented on Low Dose quetiapine. She discussed the package insert dosing for approved Indications and what the initial, recommended and Maximum Doses were. Also discussed was the titration schedule per the package insert. • Dose titration is quick – by day 3, the daily dose is > 100mg regardless of diagnosis Profiles were pulled of patients that had three or more fills of quetiapine 25mg, 50mg, or 100mg tablet strengths in 90 days. • 565 patients were identified. Medication profiles were reviewed of 100 of these patients due to time constraints. Dr. Gennrich presented diagrams/charts on 100 sample patients:

		• 54 had a Total Daily Dose ≤ 100mg
		  ○ 1 - 12 mg
		  ○ 2 - 25 mg
		  ○ 21 – 50mg
		  ○ 2 – 75mg
		  ○ 28 – 100mg
		In conclusion, it was asked if it would be possible to look at diagnosis within these individuals to determine what the medication was being prescribed for specifically.

➢ **Study Proposals for Next Quarter** • Multiple dosage forms of quetiapine prescribed concomitantly	Mark England, Pharm.D.	**Slide 126** 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 127 – 128** Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	**Slides 129 - 133** Dr. Eide discussed the top medication classes

		contributing to spend and the trend drivers for Idaho Medicaid. She also discussed the cost management strategies being deployed by the Idaho Medicaid Pharmacy Unit. And finally, Dr. Eide showed a two year Pharmacy Reimbursement vs. Net Spend trend line graph. The Idaho Medicaid net cost per claim of $40.39 is below the average of all States in the Magellan book of business at $43.46.
➢ **Adjourn, 1:30pm**	Mark Turner, M.D.	

Next Meeting: TBD 2017