Idaho DUR Board Meeting Minutes

Date: April 20, 2017 **Time:** 9am-12:30pm

Location: Holiday Inn Boise Airport 2970 West Elder Street, Boise, Idaho, 83705

Moderator: Ryan Heyborne, M.D.

Committee Member Present: Wayne Baures, RPh, Paul Cady, Ph.D., Elaine Ladd, Pharm.D., Perry Brown M.D., Matthew Hyde, Pharm.D.,

Others Present: Tami Eide, Pharm.D., Christopher Johnson, Pharm.D., Jane Gennrich, Pharm.D., Keshia Schneider, Mark England, Pharm.D.[☆], Brandi Mayes[☆]

[☆]Magellan Rx Management

AGENDA ITEMS	PRESENTER	OUTCOMES/ACTIONS
Committee Business ➢ **Call to Order**	Ryan Heyborne, M.D.	Dr. Ryan Heyborne, called the meeting to order. DUR_4_20_2017_Final.pdf
➢ **Review of Minutes from February 16, 2016**	Ryan Heyborne, M.D.	Minutes were approved as written.

➢ **American Drug Utilization Review Society (ADURS)**	Jane Gennrich, Pharm.D.	**Slides 2 – 14** Dr. Gennrich attended meeting February 23-25, 2017 in Scottsdale, Arizona. 41 States were represented. Dr. Gennrich presented highlights from the meeting which included but not limited to: Diabetes Management Rheumatology Hemophilia Dr. Gennrich then presented highlights from round table discussion. Each state had 3 minutes to highlight what they had been up to over the past year. Multiple states implementing MME restrictions for Opioids. All states struggling with how to handle concomitant opioid and benzodiazepine use. Most states now have and utilize PMP. Most states are requiring some sort of prior authorization for various psychotropic drugs for young children (age varies by state). Multiple states have a pediatric psychiatrist that reviews

		requests and provides education and alternatives to prescribers. States that have managed care plans voiced frustration over lack of control and stated that staffing has actually increased to oversee contracts than previously needed when they managed drug therapy through Medicaid directly. Hepatitis C management still ranges from open access to F3/F4 only. All states having difficulty getting post-treatment SVR test results. Dr. Gennrich presented an overview of the NEW DRUGS that were presented as well as PIPELINE REVIEW of future medications highlighted by the introduction of a new approach to the treatment of migraines. No questions or comments.
➢ **Ongoing Reviews** • Narcotic Prescribing Improvement Plan o Top 150 Utilizers	Tami Eide, Pharm.D.	**Slides 16 – 27** Dr. Eide presented updates to the Top 150 Utilizer project. She specifically went into detail on 5 members and the review, intervention letters and feedback from the prescribers. On all five, there were no changes to drug therapy after the intervention letters were sent.

		Next steps were discussed and moving forward the top 150 will be based on MME versus number of opioid claims.
• Narcotic Prescribing Improvement Plan ○ Methadone	Chris Johnson, Pharm.D.	**Slides 28 – 40** Dr. Johnson presented background data on methadone nationally. He then presented both the Methadone Initial Request PA form and the Methadone Reauthorization PA form. Dr. Johnson then presented comparative data for Idaho Medicaid after changing to non-preferred status (4Q2015 through 1Q2017). Methadone utilization has decreased 45% since designation of non-preferred status and institution of prior authorization requirements. Total patients and total claims overall have decreased while the number of unique prescribers has remained the same over the past three quarters. No change was noted though with the percentage of patients on greater than 40 mg/day of methadone.
• Buprenorphine and benzodiazepine concomitant use	Jane Gennrich, Pharm.D.	**Slides 41 – 55** 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.

		Dr. Gennrich reported that PDMP Interconnect now includes a total of 21 states including Idaho. Dr. Gennrich reviewed new Federal regulations on buprenorphine prescribing which 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. She also discussed new guidelines to be implemented that will enable nurse practitioners and physician assistants to prescribe buprenorphine. Nurse practitioners and physician assistants will be able to complete the 24 hours required training and seek to prescribe buprenorphine for up to 30 patients beginning in early 2017. HHS also is announcing its intent to initiate rulemaking to allow NPs and PAs who have prescribed at the 30-patient limit for one year, to apply for a waiver to prescribe buprenorphine for up to 100 patients. For NPs and PAs in Idaho to prescribe: Idaho's Board of Medicine has stated that Physician Assistants can only treat and prescribe in according with their supervising physician's capabilities. If the MD doesn't have a waiver to prescribe buprenorphine for the treatment of opioid addiction, then the physician assistant cannot obtain a waiver. Additional visual data was presented via graphs and tables. • Total number of participants on oral buprenorphine increased this past

		quarter while those paying cash for an opioid remained similar to previous quarters. • Patients on concomitant benzodiazepines while on buprenorphine also remained similar to previous quarters. • Patients paying cash for opioids AND on concomitant benzodiazepines while on buprenorphine remained the same at 12. It was noted by observation both in the Idaho Clinical Call Center and prescriber offices that many of the new patients starting on oral buprenorphine are in their early 20's.

• Hepatitis C Update	Chris Johnson, Pharm.D.	**Slides 56 – 70** Dr. Johnson presented the quarterly Hepatitis-C Outcomes Report for 1st Quarter 2017 (1/1/2017-3/31/2017) A total of 44 requests for treatment were submitted and 21 were approved, 17 denied, and 6 were pending, waiting for additional information for review to be submitted. A total of 18 males and 3 females were approved for which 10 patients were approved for Harvoni, 10 for Epclusa, and 1 for Zepatier. The most prevalent genotype of approved patients was Genotype-1 (12 patients). Genotype-3 (5 patients), Genotype-2 (3 patients), and Genotype-4 (1 patient) made up the remainder of approved patients. For approved requests, there were 5 patients with F4 staging, 6 with F3 staging, and 10 with F2. Patients with documented cirrhosis accounted for 52% of the approved patients. A total of 17 patients were denied for not meeting criteria. Dr. Johnson reported 9 males and 8 females did not meet fibrosis staging criteria for approval. The hepatitis-C agents denied were Harvoni (7), Epclusa (9), and Viekira Pak (1). Liver fibrosis data submitted for denied patients for the following stages were reported: F0 staging (6), F1 staging (5), F2 staging (0), F3 staging (4), F4 staging (1) and 1 did not report staging. The requests were denied for

		not meeting liver fibrosis criteria (11), active substance abuse (3), and no follow up response (3). Total amount reimbursed in 1Q2017 was $1,748,914 for Hepatitis C agents. Dr. Johnson announced that on April 7, 2017, the FDA approved Sovaldi (sofosbuvir) and Harvoni (ledipasvir/sofosbuvir) to treat HCV infections in children ages 12 to 17 years of age. He reviewed the specifics of these indications.
• Foster Children	Tami Eide, Pharm.D.	**Slides 71 – 90** Dr. Eide presented the 2016 Update on Foster Children and Psychotropic Drugs. The total number of foster children in Idaho was 2,660 and the total number of non-foster children was 244,871. The percentage prescribed psychotropic drugs in Idaho Medicaid was 18.9% for foster children (total number 2,660) and 8.1% for non-foster children (total number 244,871). All foster children qualify for Medicaid. Dr. Eide then presented slides that detailed a comparison of the utilization patterns and costs of the different psychiatric drug classes for foster and non-foster children. Overall a higher percentage of foster children than non-foster children received

		psychotropic drugs in the ADHD, antianxiety, mood stabilizer, antidepressant and atypical antipsychotic drug classes. The number of claims for each drug class did not differ significantly for foster children and non-foster children receiving drugs in those drug classes. The specialties of prescribers varied across the State of Idaho. There is a very limited number of psychiatric physician specialists in the State and per the data more than half of the psychotropic medications are prescribed by mid-level practitioners. There has continued to be cross agency coordination with Family and Community Services (Welfare Division), Medicaid, Optum, and Magellan Rx.
• Second-Generation Antipsychotic Use in children < 6 years old	Tami Eide, Pharm.D.	**Slide 91** Dr. Eide provided an update as to the current status of the project.
➢ **Current Interventions/Outcomes Studies**		
• Codeine Use in Children	Jane Gennrich, Pharm.D., Mark England, Pharm.D.	**Slides 93 – 109** Dr. Gennrich presented information from the American Academy of Pediatrics (AAP) and

		specifically from a report in the October 2016 issue of Pediatrics, Codeine: Time to Say "NO". Dr. Gennrich then presented data specific to the Idaho Medicaid Population: Between August 1 and October 21, 2016, there were 287 claims with 274 unique patients identified. (13 patients with two paid claims each) with a total of $3723 paid to pharmacies. In looking at the paid claims for patients: • 1% for 0-6 years of age • 24% for 7-11 years of age • 47% for 12-15 years of age and • 28% for 16-17 years of age. Focusing on children less than 12 years old, 68 paid claims for 67 unique patients were identified. There were 58 prescribers. In looking at the taxonomy of these prescribers, there were 14 Dentists, 14 Physician Assistants, 10 Family Practice physicians, 9 Nurse Practitioners, 8 Surgeons, 8 Emergency physicians, 2 Ophthalmologists, 1 Pediatrician and 1 Internal Medicine physician. Dr. England presented details on the report of all prescribers of codeine products to a recipient under the age of 18 years in the past six months:

		471 unique prescribers for 973 unique recipients were identified. 471 letters along with survey response forms were mailed out on 3/9/2017 to the prescribers of these patients along with a list of their patients who had a prescription filled. A Fax blast was then sent out to pharmacies week of March 13th. As of 4/10/2017 we had received 126 survey response forms back from prescribers. On 3/20/17 the drug database was updated so that claims started denying at the pharmacy for anyone < 18 years. Message to pharmacy with denial: Product/Service Not Covered for Patient Age Dr. England then went over numerous responses received from the prescribers. Dr. Gennrich provided feedback from the IDHW Clinical Call Center.
• Tramadol Use in Children	Jane Gennrich, Pharm.D., Mark England, Pharm.D.	**Slides 110 – 122** Dr. Gennrich presented information from the FDA Drug Safety Communication (9/21/) and the Ultram (tramadol) package insert recommending to not use tramadol in children. She then presented data specific to the Idaho Medicaid Population:

		Between November 1, 2015 and October 31, 2016 there were 1158 claims for 803 unique patients at a payment to pharmacies of $12,688 for those less than 18 years of age. • 0-6 years of age, none • 7-11 years of age = 6% • 12-15 years of age = 48% • 16-17 years of age = 46% Looking at the taxonomy of prescribers the highest groups were surgeons, physician assistants, family practice physicians, ER physicians and pediatricians followed by OB and urologists and the lowest number of prescribers were among dentists, podiatrists, students, a medical examiner and "other." Dr. England then presented the Idaho Intervention study. A report was run to identify all prescribers of tramadol products to a recipient under the age of 18 years in the past three months. 113 unique prescribers for 127 unique recipients were identified.

		On 4/5/2017, 113 letters along with survey response forms were mailed out to the prescribers with a list of their patients who had a prescription filled. Fax blast was sent out to pharmacies week of April 10th. As of 4/10/2017 we had not received any survey response forms back from prescribers. On 4/17/17, the drug database was updated so that claims started denying at the pharmacy for anyone < 18 years. Message to pharmacy with denial: Product/Service Not Covered for Patient Age
• Paroxetine Use in Children	Jane Gennrich, Pharm.D., Mark England, Pharm.D.	**Slides 123 – 137** The P&T Committee in November 2016 expressed concern about the usage of paroxetine in children < 18 years old due to both lack of efficacy and incidence of side effects. Dr. Gennrich reviewed an FDA Statement regarding Paxil for Children from June 19, 2003 and the current package insert. Dr. Gennrich then presented past Idaho Medicaid specific data:

		Currently prior authorization is not required for patients ≥ 6 years old.
		
		Paid claims for paroxetine in children < 18 years of age between 7/1/2016 – 12/31/2016 were reviewed and 86 patients were identified.
		
		• Breakdown by age was provided
		  ○ Age 9 = 1
		  ○ Age 10 = 0
		  ○ Age 11 = 2
		  ○ Age 12 = 5
		  ○ Age 13 = 5
		  ○ Age 14 = 6
		  ○ Age 15 = 16
		  ○ Age 16 = 26
		  ○ Age 17 = 25
		
		Of the 86 patients with paid claims between 7/1/16 – 12/31/16, only 46 had paid claims between 11/1/16 – 12/31/16 showing a discontinuation rate of 47%.
		
		On 4/24/17, the minimum age of paroxetine that will pay at the pharmacy with prior authorization not required for this preferred SSRI (immediate release formulations) will be changed to 18.

		Dr. England then discussed the Idaho intervention study data. A report which identified prescribers of paroxetine to patients under the age of 18 years in the past three months. 21 unique prescribers for 22 unique recipients were identified for recipients under the age of 16 on 3/13/2017. Per the DUR Board recommendation, prior authorizations were entered for patients who are currently 16 or 17 years of age with an end date on their 18th birthdate. On 3/21/2017 21 letters along with an age override PA form were mailed out to the prescribers with a list of their patients who had a prescription filled. Fax blast was sent out to pharmacies week of April 12th. (Copy of fax blast is in the packet) As of 4/10/2017 we had received 0 PA forms back from prescribers. As of 4/10/17 no feedback or responses have been received from prescribers or pharmacies.
• Temazepam – No longer a Preferred Sedative	Jane Gennrich, Pharm.D., Mark England, Pharm.D.	**Slides 138 – 143**

		Per Idaho Medicaid's Pharmacy & Therapeutics Committee recommendation, temazepam 15mg and 30mg capsules have switched from preferred to non-preferred status effective 1-18-17. The other strengths of temazepam were already non-preferred. The current preferred agents are zolpidem immediate release (unchanged for years) and Rozerem (ramelteon). The P&T Committee wanted to have a non-controlled sedative available as a preferred agent that would not require prior authorization. Current patients who have a paid claim between 9-1-16 and 12-31-16 were identified: 398 unique recipients with 1203 paid claims. Most patients are filling their prescription monthly with 30 capsules monthly being the most common quantity. Dr. England presented the specifics of the Idaho intervention study. Identified prescribers of temazepam in the past three months. 211 unique prescribers for 324 unique recipients were identified. A DUR letter with an attached Sedative-hypnotic PA form and list of temazepam patients was sent to prescribers of current temazepam patients on 3/9/17.

		Emphasized concerns about safety and efficacy of a long-term benzodiazepine, especially if the patient is concurrently on an opioid. Prescriber needs to fill out a prior authorization form if they want the patient to continue temazepam, including medical necessity justification, reason an alternative sedative cannot be used, and screening for substance abuse. Fax blast was sent out to pharmacies on March 15th. Implementation date set for 5/1/17 to allow time for prescribers to send in prior authorization requests. As of 4/10/2017 we had received 2 PA forms back from prescribers and only one response which stated prescriber was not in their office and the patient is not under care of their office.
➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	**Slide 144** Nothing specific was brought up at this time.
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	**Slides 145 – 146** Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	**Slide 147**

		Dr. Eide discussed the CMS revisions of outpatient drug rules and reimbursement of medications. Dr. Eide also described new workflow with the Idaho Clinical Call Center. Dr. Eide also made the Board aware of the increased number of faxes specifically related to Cover My Meds which is a third party electronic prior authorization service.
➢ **Adjourn, 12:30pm**	Ryan Heyborne, M.D.	

Next Meeting: July 20, 2017