Idaho DUR Board Meeting Minutes

Date: January 25, 2018 **Time:** 9am-12:00pm

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

Moderator: David Agler, M.D.

Committee Member Present: David Agler, M.D., Dawn Berheim, 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.[☆]

[☆]Magellan Rx Management

AGENDA ITEMS	PRESENTER	OUTCOMES/ACTIONS
➢ **Call to Order**	David Agler, M.D.	Dr. David Agler, Chairman, called the meeting to order.  DUR_01_25_2018_Final.pdf
➢ **Review of Minutes from October 19, 2017**	David Agler, M.D.	Minutes were approved as written.
➢ **MAT Buprenorphine Therapy**		**Slide 2**
• Buprenorphine vs Buprenorphine/Naloxone	Jane Gennrich, Pharm.D.	**Slides 3 – 29**

		Dr. Gennrich presented the current prior authorization form for Opiate Dependence Treatments and focused on Buprenorphine Monotherapy. Buprenorphine misuse potential was then presented and a more in depth look at the abuse and diversion of generic buprenorphine without naloxone with information coming from the Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS®)organization. RADARS® found that buprenorphine alone is abused at a much higher rate than the buprenorphine/naloxone combination products and fetches a higher street price. Information on the side effects of buprenorphine and its use in pregnant or breastfeeding women was provided. The buprenorphine monotherapy and buprenorphine/naloxone formulations have nearly identical effects when used as directed. The naloxone component is minimally active unless injected. Recommendations for the clinical use of one are also valid for the other, unless specifically noted otherwise. Use of the monotherapy tablets has been discouraged due to concerns about abuse and diversion. Information was presented from an abstract: Therapeutic switch to buprenorphine/naloxone from buprenorphine alone: clinical experience in an Italian addiction centre. The conclusion from this study was that only 2% of patients attempted the intravenous misuse of buprenorphine/naloxone, none of whom experienced any gratifying effects. Opioid-dependent patients maintained on buprenorphine monotherapy can be safely switched to a sublingual buprenorphine/naloxone tablet without any loss of treatment effectiveness. Buprenorphine/naloxone can be administered in an outpatient or primary care setting, and effectively controls cravings

		and withdrawal symptoms. Patient satisfaction was high, making retention in treatment more likely. Current use recommendations from Washington and Oregon were presented to the committee for a comparison to the states nearby. Both states prefer buprenorphine/naloxone combination therapy over buprenorphine monotherapy. Dr. Gennrich presented the Idaho Medicaid utilization from 7/1/17-9/30/17 of both monotherapy and combination therapy and went into detail as to the reason given for buprenorphine monotherapy. An in-depth look at the prescribers of buprenorphine and buprenorphine/naloxone was provided. When the data was presented it shows that there are only a few prescribers who mainly use monotherapy. Side effects such as headache, nausea, vomiting are insufficient reasons to switch from combination therapy to monotherapy. The committee recommended that buprenorphine monotherapy be restricted to pregnant patients.
• Buprenorphine or Buprenorphine/Naloxone Without Concurrent Psychotherapy	Tami Eide, Pharm.D.	**Slides 30 – 48** Dr. Eide presented information on the Buprenorphine MAT Therapy Psychotherapy Component. The SAMHSA definition of Medication-assisted treatment (MAT) is the use of medications <u>in conjunction with counseling and behavior therapies</u> to treat substance use disorders and prevent opioid overdose. The combination of medication and behavioral therapies is the most effective treatment and increases the likelihood of cessation and prevents relapse. Other benefits of "whole" approach:

		reduction in risk of overdose, improvement in social functioning, decreased criminal activity, and decreased infectious disease rates.
		
		Dr. Eide provided the Rules and Regulations from the Drug Addiction Treatment Act of 2000 and 42 CFR 8. She discussed individual therapy, group counseling, family behavior therapy, motivational enhancements and motivation incentives as the types of behavioral therapies recognized and each of their roles in the recovery process.
		
		She discussed the goals of the current study for evaluation of Psychosocial Therapy in Buprenorphine-based MAT Recipients:
		
		• Evaluate whether patients receiving continuous buprenorphine-based MAT are receiving concurrent psychotherapy
		
		• If receiving therapy, is that therapy appropriate?
		
		• If not receiving therapy, coordinate with other Health and Welfare programs
		
		  • Office of Mental Health and Substance Abuse through the Optum contract
		
		  • Division of Behavioral Health – Substance Use Disorders
		
		Dr. Eide then gave the Methodology and Evaluation Plan moving forward. Paid pharmacy claims by patient were compared with Truven reports of any psychotherapy billed during the same time period.
		
		Results were then presented. Excluding Belbuca (used for pain only and not MAT), there were 442 unique patients identified between January 2010 and September 2017 who had a paid claim for a

		buprenorphine product. Of those, 161 (36%) had a psychotherapy payment and 281 (64%) had no psychotherapy payment. Of the 281, a smaller sample size of 110 patients was evaluated and data specific to these patients was presented by Dr. Eide. In 59% of the patients there was a concurrent psychiatric diagnosis and it was noted that most of the patients had presumed very good or excellent medication compliance based on prescription fills. There were 50 unique prescribers identified and the range of patients/prescriber for these patients was 1-7. It was recommended by the Board that therapy documentation of concurrent behavioral therapy should be built into the PA Process for this class of medication.
➢ **Emerging Trends in Medicaid-Opioids Follow-up Report of October 2017 Meeting in Columbia, SC**	Chris Johnson, Pharm.D.	**Slides 49 – 65** Dr. Johnson gave an overview of the meeting he attended in South Carolina by the CMS Center for Program Integrity. The Meeting/Course was to bring together state, federal, and law enforcement partners to explore topical information concerning opioid misuse. Dr. Johnson shared many of the slides from the Center that were presented at the 3-day meetings. There was a group discussion to identify vulnerabilities of State Medicaid Agencies that are fighting the opioid crisis. The priorities were improving access to treatment and recovery services, advancing better practices for pain management, and promoting use of overdose-reversing drugs. Dr. Johnson then concluded by going over the 4 areas of identified vulnerabilities.

		1. Access to and sharing of prescription drug monitoring program (PDMP) data 2. Prescribing practices and policy 3. Oversite issues 4. Education needs
➢ **DEA Engagement on Opioid Abuse Issues**		**Slide 66**
• Report of Recent Workshops	Chris Johnson, Pharm.D.	**Slides 67 – 82** Dr. Johnson presented slides going over the highlights from the Pharmacy Diversion Awareness Conference put on by the DEA and held in Boise on October 22-23, 2017. It was designed to address the growing problem of diversion of pharmaceutical controlled substances in the United States. The objective of the conference was to educate pharmacists/technicians and pharmacy loss prevention personnel on ways to address and respond to potential diversion activity. Topics of the conference included: Drug Trends; Drug, Drugs, and More Drugs; Idaho Board of Pharmacy Update; Combat Methamphetamine Epidemic Act 2005; Medicare Pharmaceutical Diversion, and Drug Theft and Robberies. Dr. Johnson gave a quick overview of each of these topics. In conclusion Dr. Johnson shared the code of Federal Regulations for prescriptions "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of professional practice."

		And the point that: A pharmacist, by law, has a corresponding responsibility to ensure that prescriptions are legitimate. • When a prescription is presented by a patient or demanded to be filled for a patient by a doctor's office, a pharmacist is NOT obligated to fill the prescription. • The responsibility for the proper prescribing and dispensing of controlled substance is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription.
• Personal Contact and Referrals	Chris Johnson, Pharm.D. David Agler, M.D.	**Slide 83** Dr. Johnson and Dr. Agler gave an overview of their thoughts on the conference and the interactions they had with the attendees and presenters.
➢ **Methadone Utilization Update**	Chris Johnson, Pharm.D.	**Slides 84 – 96** Dr. Johnson presented background data on methadone nationally. He then presented Idaho Medicaid prior authorization criteria for both an initial request and for reauthorization. Dr. Johnson then presented comparative data for Idaho Medicaid after changing methadone to non-preferred status (4Q2015 through 4Q2017). Methadone total patients, total claims and unique prescribers continue to decrease since the change to non-preferred status. The percentage of patients on greater than 40 mg/day of methadone has decreased for the second straight quarter and there has been a

		shift to a greater percentage of patients equal to or lesser than 40 mg/day. The IDHW Pharmacy Unit continues to work with prescribers, pharmacies and patients to decrease the use of methadone.
➢ **Idaho Opioid Equivalent Dosing Project**	Mark England, Pharm.D.	**Slides 97 – 113** Dr. England presented an update to the Idaho Opioid Equivalent Dosing Project to the Board. He walked through the current management processes set in place by the IDHW Pharmacy Unit and how the Morphine Milligram Equivalence (MME) Edit will add to these current processes. The goal is to require prior authorization if a patient exceeds the 90 MME per day threshold. According to the CDC, clinicians should avoid increasing above this or justify why a higher dose is necessary. Because of the high current number of recipients that are above the 90 MME level, this was operationalized by prior authorizing any patient above the 90 MME level within the previous 90 days for up to a year to allow for continuity of care. This allows the IDHW Clinical Call Center to focus on recipients who reach this threshold moving forward and those who are currently above this level will have an intervention in the future. Dr. England presented data from 4Q2017 to the Board and explained that the edit was made operational on July 19, 2017. There was also quarterly data presented showing the trend from 1Q2017 through 4Q2017. There has been a 14.79% decrease from 1Q2017 to 4Q2017 in Members on Opioids and a 14.30% decrease in Opioid Members on > 90 MME during this same time period.

➢ **Hepatitis C Utilization Update**	Chris Johnson, Pharm.D.	**Slides 114 – 128** Dr. Johnson presented the quarterly Hepatitis-C Treatment Utilization Report for 4th Quarter 2017. A total of 48 requests for treatment were submitted with 18 approved and 16 denied on initial evaluation. 14 were initially pended with a request for additional information to be submitted for review. A total of 11 males and 7 females were approved for treatment of which 8 patients were approved to receive Harvoni, 6 to receive Epclusa, 3 to receive Mavyret, and 1 to receive Vosevi. The most prevalent genotype of approved patients was Genotype-1 (11 patients) followed by Genotype-2 (4 patients) and Genotype-3 (3 patients). For approved requests, there were 5 patients with F4 fibrosis staging, 3 with F3 staging, 9 with F2, 1 with F1, and 5 with F0. Patients with documented cirrhosis accounted for 50% of the approved patients. A total of 16 unique patients were denied for not meeting criteria. The hepatitis-C agents denied were Harvoni (5), Epclusa (5), Mavyret (5), and Vosevi (1). Dr. Johnson reported that 7 patients were denied for not meeting fibrosis scoring, 5 for no response to follow up data requests, and 5 for active substance abuse. Total amount paid to pharmacies in 4Q2017 was $1,243,228 for Hepatitis C agents. Dr. Johnson announced that Idaho Medicaid new HCV therapeutic criteria effective 1/1/2018 would cover treatment for Hepatitis C patients with Fibrosis scoring of F0-F4 if they meet all other criteria. Current preferred agents are Mavyret, Epclusa, and Vosevi.

➢ **Long-Term Use of PPIs**	Tami Eide, Pharm.D.	**Slides 129 – 158** Dr. Eide presented information regarding the Long-Term Use of Proton Pump Inhibitors (PPIs). Factors for consideration included that the short-term use of proton pump inhibitors is usually considered safe (OTC availability), there is a definite overutilization of proton pump inhibitors, many patients continue to take proton pump inhibitors beyond the recommended course of treatment, and that they are often prescribed at unapproved twice daily dosing. FDA indications for use and potential adverse outcomes of long-term use of PPIs were reported and included a model to evaluate causality vs association when evidence is primarily observational. She reported on the mechanism of those adverse effects with the best evidence. The American Gastroenterological Association best practice recommendations on long-term use were presented. Their recommendations are broken down for which indications have benefits that outweigh risk, which indications can be considered for long term use and those indications for which long-term PPI use should not be indicated. Idaho Medicaid Utilization data from 12/1/2015 to 11/30/2017 was provided. There were 19,444 unique patients, 136,259 claims and over 4 million dollars in payments to pharmacies. In the analysis, 547 unique patients were identified with ≥ 730 days of therapy. There were 1297 claims for 127 unique patients who had ≥ 2 doses per day. Upon more in-depth analysis there were 39 patients with > 1 dose per day for ≥ 12 months. Dr. Eide presented possible interventions which included education, and restrictions by means of PA by diagnosis, Quantity Limits and Duration Limits.

		One of the educational mechanisms she focused on was the concept of "deprescribing" which is defined as a planned and supervised process of dose reduction or stopping of medication that might be causing harm or might no longer be providing benefit. She gave an example of the Canadian Deprescribing Network (CADEN) evidenced-based guideline and algorithm. Restrictions and criteria for the following States were presented: Oregon, Missouri, Arkansas, New York, Colorado, and Washington. Next steps for Idaho Medicaid were discussed and included education and restrictions. It was suggested to consider the possibility of 60 days with no PA and then attempt to step down therapy.
➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	**Slide 159** Potential studies for upcoming DURs include: Benzodiazepines and Anxiety without SSRIs or SNRIs, Quetiapine low dose, and Typical vs. Atypical Antipsychotics.
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	**Slides 160 – 161** Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	**Slide 162** Dr. Eide provided an update on the IDHW Clinical Call Center.

➢ **Adjourn, 12:00pm**	David Agler, M.D.	

Next Meeting: April 19, 2018