Idaho DUR Board Meeting Minutes

Date: July 19, 2018 **Time:** 9am-12:00pm

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

Moderator: Mark Randleman, DO

Committee Member Present: Dawn Berheim, Pharm.D., Matthew Hyde, Pharm.D., Paul Cady, Pharm.D., Wayne Baures, RPh.

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

[☆]Magellan Rx Management

AGENDA ITEMS	PRESENTER	OUTCOMES/ACTIONS
➢ **Call to Order**	Mark Randleman, DO	Dr. Mark Randleman called the meeting to order.  DUR_07_19_2018_Final.pdf
➢ **Review of Minutes from January 25, 2017**	Mark Randleman, DO	Minutes were approved as written.
➢ **DUR Annual Report – Highlights**	Tami Eide, Pharm.D.	**Slides 2 – 22** Dr. Eide began by giving the background on why the DUR program exists. She then explained to the Board how there were 125 questions this year and 8 attachments that were also submitted to complete the Annual Report. There was an increased interest in ProDUR related questions for this report and moving forward that

		will be closely watched to determine if this is going to be a CMS focus. Dr. Eide then went into detail on the top 10 PA requests by drug name, top 10 PA requests by drug class, top 5 claim denial reasons, top 10 drug names by amount paid/percent of total spend, generic drug utilization and expenditure, cost savings/cost avoidance, fraud, waste and abuse detection, provider and beneficiary fraud and abuse, PDMP usage, retrospective educational outreach summary, DUR Board activities, innovative practices, and executive summary highlights. She provided a comparison to the previous report year in most of these areas. The DUR Board had no questions or comments.
➢ **CMS Substance Use Disorder Measures**	Tami Eide, Pharm.D.	**Slides 23 – 39** Dr. Eide presented information as it related to a part of the CMS Medicaid/CHIP Core Set of Health Care Quality Measures. Substance Use Disorder (SUD) measures are voluntary at this time, but a high priority for CMS and there is some speculation that a State's match rate could be tied to that State's quality performance on Adult and Child Core Sets in the future. There are four measures in the Adult Core Set for substance use disorder; however, only two pertain directly to pharmacy so those are the focus currently. 1. Use of opioids at high dosage in persons without cancer. 2. Concurrent use of opioids and benzodiazepines.

		Dr. Eide presented the details on defining the data elements for which these two measures are to be reported. Estimates using the Idaho Medicaid data was presented by Dr. Eide. Dr. Eide then presented the Board with additional potential measures for the DUR Board to consider for both Adult and Child Core Measures. The DUR Board brought up the question that when looking into this data, if at all possible they would like to see a geographical breakdown across the State.
➢ **Idaho Opioid Equivalent Dosing Project**	Mark England, Pharm.D.	**Slides 40 - 55** 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 complemented those 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. The ~3,700 PA's entered last year will expire on July 19, 2018 and all members > 90 MME will require a PA moving forward. Dr. England presented data from 2Q2018 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 2Q2018. There has been a 22% decrease from 1Q2017 to 2Q2018 in Members on Opioids and a 25% decrease in Opioid Members on > 90 MME during this same time period.
➢ **Idaho Opioid Utilization**	Chris Johnson, Pharm.D.	**Slides 56 - 63** Dr. Johnson presented a comparative analysis of total Idaho opioid claims vs. total Idaho Medicaid opioid claims. Data for the total Idaho claims was received from the Idaho Board of Pharmacy for 2014 through 2018 ytd. Based off these values and reports for Idaho Medicaid specifically, the annual percentage of Medicaid Opioid claims in Idaho was calculated and presented. Dr. Johnson presented comparative charts and tables to the DUR Board. Total Opioid Claims are decreasing in Idaho on a whole and Idaho Medicaid claims show a 29% decrease from 2014 to 2017. Current trends for 2018 suggest a continued decrease of opioid utilization in Idaho. The Board suggested that a further breakdown and comparison by age be considered moving forward as Medicaid as a whole has a younger population than the general population of Idaho.
➢ **High Utilization of Benzodiazepines**	Jane Gennrich, Pharm.D.	**Slides 64 – 67** Dr. Gennrich presented data looking at patients routinely filling more than 90 tablets monthly of benzodiazepines from 2/1/2018 – 5/31/2018. Currently drug quantities for benzodiazepines in the drug database range from 1 – 8 tablets daily and future plans are to lower the number of tablets allowed per day without prior authorization.

		Discussion was brought up that the PA was intended to identify patients and start to question the clinical rationale for these doses and to require prior authorization for new patients being prescribed high doses of benzodiazepines.
➢ **Two or More Benzodiazepines**	Jane Gennrich, Pharm.D.	**Slides 68 – 89** This study was done to identify when more than one benzodiazepine was prescribed to a patient at the same time (at least 60 days of overlapping prescriptions). Dr. Gennrich reviewed the chemistry and pharmacology of benzodiazepines. She then presented the background, material and method, interpretation and summary leading up to the Idaho specific data for two or more benzodiazepines. A report was initially run to identify claims between 8/1/2017 and 1/31/2018. Dr. Gennrich presented graphs and diagrams looking at the number of patients and the various breakdown of the data to the Board. A new report was run collecting data between 2/1/2018 – 5/31/2018 and 140 patients were identified of which Dr. Gennrich reviewed 100 patient profiles to gather more detailed information. She then presented her findings looking at concomitant opioids and their doses, benzodiazepine specific data, and based on her results she sent DUR letters to prescribers of 64 patients who were still on two benzos when the patient's PMP was reviewed. No letters were sent to prescribers of epilepsy patients or if the patient was only on one benzodiazepine by the time the patient's profile was reviewed.

		Dr. Gennrich went on to show additional charts and data from her findings. She also shared some of the responses from the 10 letters she received back from her mail outs. While many responses state that patient is on "prn" therapy for anxiety, the PMP documents that the patients are filling prescriptions typically for 90 tablets every 30 days for "tid prn" dosing regimens. The Board suggested considering a TD Pro-DUR hard stop if the number of patients continues to be high in the future.
➢ **Niacin Extended Release Utilization**	Chris Johnson, Pharm.D.	**Slides 91 - 99** In response to a question during the April 2018 P&T Committee meeting, Dr. Johnson presented findings for the utilization of Niacin Extended Release in the Idaho Medicaid Population. He covered the indications and limitations of use of this specific product. Currently it is listed as a preferred agent without prior authorization and the P&T Committee recommended making all niacin products non-preferred. Dr. Johnson presented data collected on claims with a service date between 1/1/2018 – 4/20/2018. There was a total of 17 members with a total of 51 claims. Based on these findings it was determined that the utilization is small and will not impact resources if changed to non-preferred status.
➢ **Typical Antipsychotic Utilization**	Chris Johnson, Pharm.D.	**Slides 100 – 117**

		During the November 2017 meeting of the P&T Committee, they requested a review of typical antipsychotics and specifically looking at the short-term vs long-term use of the agents as well as "other indications" outside of psychosis? Dr. Johnson explained that he could look at total claims, utilization of typical vs atypical agents, concomitant use of typical and atypical agents, patient demographics, and diagnosis codes for patients prescribed antipsychotics. He presented some background information as to the terminology and classification associated with these agents and the hierarchical specific therapeutic class codes for the various agents. Data was obtained from April – June 2018. Dr. Johnson then presented the utilization results of this data in numerous charts, graphs, and diagrams. In conclusion, overall drug utilization of typical antipsychotics is small (2%) compared to atypical antipsychotic utilization. Overall combination typical/atypical antipsychotic utilization is small (1.6%) compared to atypical antipsychotic utilization. Haloperidol (oral) utilization is highest in both study groups (typical and typical/atypical agents) potentially being used as an acute treatment of psychosis on a prn basis. The Board recommended that further evaluation of members between 5-10 years old be looked at in more detail to determine why the typical antipsychotics are being used in this population.
➢ **Naloxone**	Jane Gennrich, Pharm.D.	**Slides 118 – 127**

		Dr. Gennrich presented the utilization of Naloxone on a quarter by quarter basis starting with 2017 Q3. 2018 Q2 saw a large jump in the utilization of Naloxone in claim volume, distinct members, total prescribers and total pharmacies. The largest use was with the Narcan 4 mg nasal spray. Of the 298 total claims from 9/1/2017 – 6/30/2018, 87 (29%) were prescribed by 59 different pharmacists. Dr. Gennrich presented two cases examples in which multiple doses were dispensed and no ER visits had been reported. This raised the question as to why three doses in two weeks and would there need to be additional follow-up with the pharmacy, prescribing pharmacist, and/or prescriber. Dr. Gennrich also shared that the Family Practice Residency was prescribing Naloxone with all their new Suboxone patients. It was also stated that it was to be on the PDMP starting 7/1/2018, but these have not shown up on that report as of yet. Moving forward the Board recommended reviewing utilization for fraud, waste and abuse.
➢ **Spinraza**	Jane Gennrich, Pharm.D.	**Slides 128 – 143** Dr. Gennrich presented a detailed report on the background of Spinraza and Spinal Muscular Atrophy (SMA). She provided information on the five clinical types of SMA and that prior to Spinraza, treatment was only supportive and this will continue with the use of Spinraza.

		Dr. Gennrich provided the mechanism of action of Spinraza and how it may improve the function of patients, but it is a treatment and not a cure. There is research being done on Gene Therapy using viral vectors and the goal is to cure the disease in the future. Idaho Medicaid has received requests for 12 patients with SMA and all have been approved. As of 6/30/2018, there have been a total of 23 doses paid for by Idaho Medicaid for eight children. Dr. Gennrich shared that Idaho Medicaid has agreed to participate in the SMARTEN (Spinal Muscular Atrophy Research: The Effectiveness of Nusinersen which is a DERP (Drug Effectiveness and Review Project) study. The following outcomes will be collected and analyzed. 1. Mortality/survival Date and reason for death 2. Motor skills As measured by CHOP-INTEND and HINE-2 3. Need for permanent ventilation (16 hours or more per day) Concerns About the Approval of Nusinersen Sodium by the US Food and Drug Administration: "Policy debates have centered on the cost of nusinersen, which has a list price of $750,000 for the first year of treatment." "There has been less discussion of the limited evidence supporting the drug's efficacy and potential harms."

		"Although the ENDEAR trial included only patients with SMA Type 1, the FDA granted marketing authority for all types of SMA, based on uncontrolled data and "high level summary results" in types other than SMA Type 1."
➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	**Slide 144** Potential studies for upcoming DURs include: Biosimilars
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	**Slides 145 - 150** Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted. He also showed details as to the various ProDUR Severity levels for each of the messages. The specific messaging levels for Idaho Medicaid Claims were also discussed and when they are set up to deny vs just message.
➢ **Benzodiazepine Opioids DR_DR Interactions**	Mark England, Pharm.D.	**Slides 151 – 173** Dr. England went into detail on the specific messaging and alerts as they relate to benzodiazepine and opioid drug-drug interactions as defined by First Data Bank. He gave a specific case study example on how the number of alerts can escalate very quickly. A report was run identifying all claims for Adi codes 2788, 2792, and 2793 from 9/1/2017-2/28/2018. Graphs and charts were presented showing the large number of claims found and the resulting status of these claims along with specific details as to the

		drugs, claims, members, prescribers, and pharmacies impacted with these alerts. The Board determined with the large number of claims impacted no changes to the current setup of the pharmacy claims system was needed at this time.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	**Slide 174** Dr. Eide provided an update on the future activities of IDHW as it relates to the State Rules for the Pharmacy Program. IDHW is proposing an increase in the number of medications on the 3-month supply list, removing cough/cold products from coverage and providing clarification language around the definitions of Preferred Drug List and the Prior Authorization Process.
➢ **Adjourn, 12:00pm**	Mark Randleman, DO	

Next Meeting: October 18, 2018 – May need to be re-scheduled due to conflicting Calendars