Idaho DUR Board Meeting Minutes

Date: November 15, 2018 **Time:** 9am-12:00pm

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

Moderator: Perry Brown, MD

Committee Member Present: Dawn Berheim, Pharm.D., Matthew Hyde, Pharm.D., Wayne Baures, RPh., Chris Owens, Pharm.D.

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

[☆]Magellan Rx Management

AGENDA ITEMS	PRESENTER	OUTCOMES/ACTIONS
➢ **Call to Order**	Perry Brown, MD	Dr. Perry Brown called the meeting to order.  DUR_11_15_2018_Final_.pdf
➢ **Review of Minutes from July 19, 2018**	Perry Brown, MD	Minutes were approved as written.
➢ **DUR Minimum Standards**	Tami Eide, Pharm.D.	**Slides 2 – 16** Dr. Eide presented information on H.R. 5799: The Medicaid Drug Review, Utilization, Good Governance Improvement Act and on H.R. 6: SUPPORT (Substance Use-Disorder Prevention that

		Promotes Opioid Recovery and Treatment) for Patients and Communities Act. Both of these legislations will set minimum standards for dealing with the opioid epidemic. The H.R. 5799: Medicaid Drug Review, Utilization, Good Governance Improvement Act is set to amend Title XIX of the Social Security Act to require as a condition of full Federal Medical Assistance Percentage (FMAP) receipt under Medicaid that state Medicaid plans have in place certain drug utilization review activities. It was introduced May 15, 2018 with certain amendments on June 12, 2018 and no further activity has been noted up to this time. Requirements include automated claims review processes for opioid refill limits, daily buprenorphine limits, maximum daily morphine equivalents and simultaneous use of opioids with benzodiazepines or antipsychotics. States must also have a program for managing antipsychotic drugs prescribed to children under 18 and children in foster care and an opioid fraud and abuse identification program in place encompassing beneficiaries, prescribers, and pharmacies. These requirements must be in place by 10/1/2019 with the same requirements for managed care and fee-for-service programs. Federal matching percentages will be reduced for those State Medicaid Programs not in compliance. Dr. Eide reviewed Idaho's input to NAMD on positives, concerns and clarifications needed. She also reported on input from ADURs on the legislation. The New Legislation, SUPPORT for Patients and Communities Act, was passed by the House and Senate and signed by the President on 10/24/2018. Many of the requirements concerning DUR and

		Medicaid are the same as H.R. 5799, but it is unclear if this will replace and negate the need for H.R. 5799. This legislation is comprehensive and includes requirements for Medicaid, Medicare and the FDA. Section 1004 of H.R. 6: Medicaid Drug Review and Utilization was reviewed. Like H.R. 5799 it will require Medicaid to have in place a claims' review automated process and safety edits (limitations) for opioid fills (i.e. refills) in excess of State identified limitations, maximum daily morphine equivalents (MME) that exceed state-defined limitations and concurrently prescribed opioids and benzodiazepines or antipsychotics. Similar requirements are also outlined for antipsychotic prescribing in children, fraud and abuse detection, reporting and exclusions. During the discussion period, it was asked what role Idaho Medicaid Provider Integrity play moving forward once this legislation is implemented. Dr. Eide will engage them in the near future to discuss this and report back to the Board.
➢ **Buprenorphine Monotherapy**	Jane Gennrich, Pharm.D.	**Slides 18 – 28** Dr. Gennrich presented the current prior authorization form for Opiate Dependence Treatments and the current requirement that the oral buprenorphine/naloxone combination be used rather than the oral buprenorphine single entity except in pregnant women. This is based on SAMHSA and national guidelines to minimize the possibility of diversion of buprenorphine single entity via the injection route. 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. Information on the side effects of buprenorphine was provided and a comparison with the combination product with nausea, vomiting, and headache were discussed as these are the three most common reasons for a request to switch from combo to mono therapy. Dr. Gennrich presented and compared the Idaho Medicaid utilization from 7/1/17-9/30/17 and 7/1/18-9/30/18 of both monotherapy and combination therapy and went into detail as to the prior authorization rationales submitted for buprenorphine monotherapy. The numbers in 2018 show a 6% decrease in the percentage of patients receiving monotherapy compared to 2017. An in-depth look at the prescribers of buprenorphine and buprenorphine/naloxone was provided based on the 2017 data. When the data was presented it shows that there are only a few prescribers who mainly use monotherapy. A letter from one of the prescribers in favor of monotherapy as the preferred formulation was shared with the DUR Board as well as a response email from two other prescribers who routinely treat patients with substance use disorder. The DUR Board recommended to stay with the current policy surrounding the use of buprenorphine monotherapy and that combination therapy should be the product of choice to minimize the possibility of diversion. Dr. Gennrich also spoke about a University of Washington Webinar she attended on this topic. This UW group of experts also stated that combination therapy is preferred. They also suggested the utilization of urine drug screens to not only check for concomitant opioid use, but also use on the buprenorphine itself.

➢ **Buprenorphine Patients Without Psychotherapy**	Tami Eide, Pharm.D.	**Slide 29** Dr. Eide shared that 442 patients had paid claims for buprenorphine products between 1/1/2010 – 9/30/2017 and that only 36% of these members had received some sort of psychotherapy during this time. Dr. Eide then provided a handout on the different types of psychotherapy that were available for Idaho Medicaid patients as well as draft letters that are being proposed to send out to prescribers of buprenorphine-based MAT as well as participants receiving MAT. The letter will give them contact information for the various types of psychotherapy available through Medicaid. The DUR Board supported these letters as a reasonable intervention. They urged the Department to consider the needs for patients that live remotely, as well as ensuring that evening and weekend hours be available. They also suggested using the word counseling rather than psychotherapy for the participant letter.
➢ **Idaho Opioid Equivalent Dosing Project**	Mark England, Pharm.D.	**Slides 31 - 45** Dr. England presented an update on 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 expired on July 19, 2018 and all members > 90 MME will require a PA moving forward. Dr. England presented data from 3Q2018 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 3Q2018. There has been a 26% decrease from 1Q2017 to 3Q2018 in Members on Opioids and a 28% decrease in Opioid Members on > 90 MME during this same time period.
➢ **Methadone Utilization**	Chris Johnson, Pharm.D.	**Slides 46 - 58** 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 3Q2018). 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 stabilized and there has been a stabilization in the percentage of patients on equal to or lesser than 40 mg/day as well. The IDHW Pharmacy Unit continues to work with prescribers, pharmacies and patients to decrease the use of methadone. High

		dose methadone utilizers require a slower tapering plan and work continues.
➢ **Two or More Benzodiazepines**	Jane Gennrich, Pharm.D.	**Slides 59 – 67** 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, materials and method, interpretation and summary leading up to the Idaho specific data for two or more benzodiazepines. Dr. Gennrich followed up on DUR Letters that were sent to prescribers of 64 patients she had discussed at the July 2018 DUR Meeting. Ten (10) responses had come back prior to the July meeting and an additional 6 responses were received after that meeting. To summarize the responses, a majority of prescribers stated that one benzo was being used for one indication and a second benzo was used for a different indication. The most common indications were anxiety and insomnia. Prior authorization will be required on therapeutic duplication for multiple benzos in the near future. For prescribers who responded to the DUR letters, a prior authorization will be proactively entered if they had requested continuation of both benzos. It was also noted that half of these patients are not on any other anti-anxiety controller medication such as a SSRI or SSNRI's.

		The Board also suggested combination benzodiazepine and amphetamine use be considered for a future DUR.
➢ **High Utilization of Benzodiazepines**	Jane Gennrich, Pharm.D.	**Slides 68 – 85** Dr. Gennrich presented data comparing patients routinely filling more than 90 tablets monthly of benzodiazepines from 3/1/2018 – 5/31/2018 and from 7/1/2018 – 9/30/2018. The number of patients had only decreased slightly. Starting with lorazepam as an example, prior to this DUR the maximum quantity per day of the 0.5, 1 and 2 mg tabs were 8, 5, and 7 respectively. The quantity allowed was changed to 3 tablets daily on all strengths beginning 10/1/2018. Between 10/1/2018 and 10/31/2018 Idaho Medicaid received 12 quantity override requests; 7 were denied and 5 were approved. Dr. Gennrich discussed these requests with the Board. For diazepam, the 2, 5 and 10mg tablets all had a quantity limit of 4 tablets daily set in the system. The maximum quantity was changed to 3 tablets daily starting 11/1/2018. Of the 814 members who had a paid claim between 7/22/18 and 10/22/18, 29 (3.6%) had at least one paid claim for more than 90 tablets/month. When looking at these 29 in detail, it was noted the 5 already had the dose reduced, 5 had discontinued diazepam, leaving 19 patients currently filling more than 90 tablets monthly. Dr. Gennrich then went on to provide the DUR Board with details on the remaining 19 patients regarding fill quantities, diagnoses and future plans for these members. Future plans for high utilization of benzodiazepines are to decrease the maximum quantities of alprazolam, clonazepam ODT and clonazepam.

➢ **Uloric Utilization and New Adverse Event Information**	Jane Gennrich, Pharm.D.	**Slides 87 – 96** Dr. Gennrich shared with the Board an FDA Safety Announcement from November 15, 2017 alerting the public that preliminary results from a safety clinical trial show an increased risk of heart-related death with febuxostat (Uloric) compared to allopurinol. On 8/22/2018, the FDA also released an updated Safety Announcement after receiving the results of the Cardiovascular Safety of Febuxostat and Allopurinol in Patients with Gout and Cardiovascular Morbidities (CARES) trial and is conducting a comprehensive review. <u>Idaho Medicaid Utilization of Uloric:</u> Ever since Uloric was approved by the FDA, allopurinol has been the preferred agent and Uloric has been the non-preferred agent. The clinical criteria as listed on the PDL (Preferred Drug List) is: Uloric will be approved for continuation of gout attacks with serum urate levels > 6mg/dl after at least 3 months of allopurinol at a therapeutic dose or with documented intolerance to allopurinol. Dr. Gennrich shared with the Board claims utilization of Uloric between 6/1/2018 to 8/31/2018. There were 9 patients with a paid claim for Uloric during this time and as a reference there were 298 patients with a paid claim for allopurinol. Of these 9 patients, 4 were female and 5 were male. Six patients had no heart disease while 3 did have heart disease based on the electronic profile of the member. All but one patient were previously on allopurinol prior to Uloric and 6 had been on Uloric for more than 1 year. The DUR Board suggested that letters should be sent out to prescribers of all 9 Uloric patients and for future PA requests there should be a screen for existing cardiovascular disease.

➢ **Cystic Fibrosis**	Jane Gennrich, Pharm.D.	**Slides 97 - 111** Dr. Gennrich shared that between 10/1/2016 – 9/30/2018 medication to treat Cystic Fibrosis accounted for a little over $7.6 million and represented 2% of the overall drug spend for the Idaho Medicaid Program. Background information was presented on the disease state and where the current medications Kalydeco, Orkambi, and Symdeko fit into treating this disease and where other drugs currently stand in preclinical and clinical trials and where they work in the disease process. Dr. Gennrich then went into detail on the timeframe of how these three medications have made it to market and the indications and costs associated with each. The final slide showed the total amount paid and the number of claims of each of these three medications from 4Q2016 to 4Q2018. Total expenditures are approximately $ 1.2 million per quarter.
➢ **Foster Children and Behavioral Health Medications**	Tami Eide, Pharm.D.	**Slides 112 – 132** Dr. Eide provided an update of foster children and behavioral health medication use in Idaho Medicaid. Idaho has been tracking utilization since 2011 when a GAO study looking at 5 states was published. A detailed look at 2017 data was presented. Overall rates for Foster Children with a Behavioral Health Medication was 17.5% and for Non-Foster Children it was 7.2%. These percentages have decreased slightly over the past few years.

		For 2017, a higher percentage of foster children received ADHD, anticonvulsants, antidepressants, antimanic and antipsychotic agents than non-foster children. Antianxiety and sedative hypnotic percentages were similar between the two groups. Breakdown of drug class by age is similar for foster and non-foster children for ADHD drugs, antianxiety and sedative hypnotic, anticonvulsants, antidepressants, antimanic, and antipsychotics. The claims per foster child were substantially higher than for non-foster children – 2.34 vs. 0.76. The cost per foster child was also substantially higher at $234 vs. $84 non-foster. The following is a breakdown by % of claims by prescriber type for foster children: Nurse Practitioner – 39% Child/Adolescent Psychiatrist/Developmental Specialist – 13% Pediatrician – 13% Physician Assistant – 12% Psychiatrist – 12% Family Practice/Internal Medicine – 11% Dr. Eide presented slides and explained how different regions within the State of Idaho have a different breakdown of Specialist, Generalist, and Mid-levels prescribing medications for these members.
➢ **Oral Health Issues From Mental Health Medications**	Chris Johnson, Pharm.D.	**Slides 133 – 145**

		Dr. Johnson shared background information on why the oral health risk of patients with mental health conditions is poorer than the general population. Compounding factors include homelessness, poor diet, tobacco smoking, disabilities, dental phobias, and barriers to accessing dental care. Side effects from psychotropic medications also contribute with xerostomia being a major risk factor. Patients with severe mental illness have 2.7 times the likelihood of losing all their teeth, compared to the general population. Dr. Johnson provided a handout that had an extensive list of medications that cause xerostomia and many agents used in the treatment of Mental Health are on the list. Looking at participant and claim counts (all participants, all drugs) for the Basic Medicaid Plan from 11/1/2017 to 1/31/2018, Dr. Johnson determined that 46% of Medicaid participants had received one or more of the therapeutic classes of Ataractics-Tranquilizers, Psychostimulants-Antidepressants and Anticonvulsants and these drugs accounted for 26% of all drug claims dispensed. He reviewed the current dental plan for Idaho Medicaid participants and what the specific dental coverage consisted of for these members. In conclusion, there are multiple factors involved in oral health issues and mental health disorders and there are limitations to the data collection and documenting of diagnosis. Oral health issues may be a problem in patients taking medications that cause xerostomia and proper education and monitoring is warranted.
➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	**Slide 146**

		Potential studies for upcoming DURs include: How many patients on antipsychotics are also on opioids, how many patients < 5 years of age as well as between 5 and 10 years of age on antipsychotics and is there a way we can survey opioid patients and check the PDMP for those paying cash in an automated way.
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	**Slides 147 - 148** Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	**Slide 149** Dr. Eide shared with the Board that Medicaid Expansion had passed and will now be up to the Legislature on how to implement services for these new members. At this time, it appears they will be enrolled in the Basic Medicaid Plan, but that could always change depending on the Legislature directives. New Medicaid Pharmacy rules are being submitted to the Legislature around the 340B program, members paying cash for controlled substances, the auto-refill process, defining of PDL and the PA Process, and expanding the list of prescription drugs that can be filled for a 3-month supply.
➢ **Adjourn, 12:00pm**	Perry Brown, MD	

Next Meeting: January 17, 2019