# Idaho DUR Board Meeting Minutes

**Date:** January 17, 2019 **Time:** 9am-12:00pm

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

**Moderator:** Mark Randleman, D.O.

**Committee Member Present:** Perry Brown, M.D., Wayne Baures, RPh., Matthew Hyde, Pharm.D., Chris Owens, Pharm.D.

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

[☆]Magellan Rx Management

| AGENDA ITEMS | PRESENTER | OUTCOMES/ACTIONS |
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| ➢ **Call to Order** | Mark Randleman, D.O. | Dr. Mark Randleman called the meeting to order.<br>  <br>DUR_1_17_2019_Final.pdf |
| ➢ **Review of Minutes from November 15, 2018** | Mark Randleman, D.O. | Minutes were approved as written. |
| ➢ **3 Month Supply List** | Tami Eide, Pharm.D. | **Slides 2 – 5**<br><br>Dr. Eide shared current Rule IDAPA 16.03.09 662.06 and then the proposed rule.<br><br>**Proposed Rule IDAPA 16.03.09 662. 07** |

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| | | **Limitation of Quantities**. Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the participant. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions:<br><br>a. Maintenance Medications. Pharmacy providers may be reimbursed for up to a three (3) month supply of select medications or classes of medications for a participant who has received the same dose of the same select medication or class of medications for two months or longer. The Director of the Department of Health and Welfare, acting upon the recommendation of the Pharmacy and Therapeutics Committee, approves the list of covered maintenance medications, which targets medications that are administered continuously rather than intermittently, are used most commonly to treat a chronic disease state, and have a low probability for dosage changes. The list of covered maintenance medications is available on the Medicaid Pharmacy website at http://medicaidpharmacy.idaho.gov.<br><br>b. Oral Contraceptive Products. Oral contraceptive products may be dispensed in a quantity sufficient for one (1), two (2), or three (3) cycles.<br><br>Key points<br><br>• Stable on therapy for at least 2 months |

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| | | • List of drugs recommended by P&T Committee and Approved by Director of Health and Welfare<br>• Criteria for inclusion consideration<br>  • Continuous not intermittent administration<br>  • Chronic disease state treatment<br>  • Low probability of a dosage change<br>• List is available on pharmacy website to allow timely changes without need for rule change<br><br>Dr. Eide then provided a handout with a listing of drug classes for the DUR Board to review and comment. The Board agreed with Dr. Eide's proposed list and suggested moving forward with this plan. |
| ➢ **Pharmacogenomic Testing** | Jane Gennrich, Pharm.D. | **Slides 6 -- 14**<br><br>The Idaho Medicaid Pharmacy Unit will be responsible for prior authorizing requests for pharmacogenomic testing for drug related tests.<br><br>Dr. Gennrich shared with the DUR Board the FDA Statement issued on 11/1/2018. The statement warned consumers about genetic tests that claim to predict patients' responses to specific medications.<br><br><u>Idaho Medicaid's Policy for Genomic Testing requests:</u> Prior authorization will be reviewed and then approved/denied by the Idaho Medicaid Pharmacy Program for requests for CPT 81225 (CYP2C9), CPT 81226 (CYP2D6), and CPT 81227 (CYP2C19). |

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| | | Requests must include:<br><br>1. Name of test requested<br><br>2. Purpose of test – must be patient and drug class specific. Note: Idaho Medicaid will not approve requests to genetically profile a patient for general knowledge or screening purposes.<br><br>In order to approve a request, the following criteria must be met:<br><br>1. Choice of drug will be determined by the results of the genomic testing. Must include reason why a usual preferred medication cannot be tried first PRIOR to genomic testing. AND<br><br>2. The drug either chosen or rejected based on the results of the genomic testing has this information listed in their package insert OR high-quality evidence is available that states that either a drug should or should not be used based on genomic testing results. Theoretical evidence is insufficient to approve a request for genomic testing.<br><br>Dr. Gennrich discussed the references used by The Idaho Medicaid Pharmacy Unit and also shared that correct interpretation of the results is vital. She shared examples of when genetic testing (not paid for by Idaho Medicaid) has already been completed and misinterpretation of the results were provided for review.<br><br>Goals for Pharmacogenetic Testing include Clinical Validity and Clinical Utility and we are not there yet. |

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| ➢ **Uloric DUR** | Jane Gennrich, Pharm.D. / Mark England, Pharm.D. | **Slides 16 - 22**<br><br>Dr. England shared with the Board that FDA Safety Communications on 11/15/17 and 8/22/18 evaluating increased risk of heart related death and death from all causes with febuxostat (Uloric) which were discussed at 11-15-18 DUR meeting.<br><br>At the November Meeting, the DUR Board suggested that letters should be sent out to prescribers of all Uloric patients and for future PA requests, there should be a screen for cardiovascular disease.<br><br>There were 9 patients identified receiving Uloric.<br><br>Letters were sent on 1/3/2019 to prescribers of current Medicaid patients receiving Uloric with the FDA Safety Communications wording. The letter also stated that the prescriber's patients currently had a prior authorization in place, so no further action was required at this time. |
| ➢ **Two or more benzodiazepines** | Jane Gennrich, Pharm.D. | **Slides 24 - 31**<br><br>Dr. Gennrich shared that a hard stop at the pharmacy for patients on two or more benzodiazepines was put into place on 12-13-18. This means that a therapeutic duplication prior authorization must be submitted to Idaho Medicaid (can no longer be overridden by the dispensing pharmacy).<br><br>DUR Letters to prescribers of 64 patients were sent out ahead of time. |

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| | | 19 responses were received by Idaho Medicaid prior to 12-13-18 (30% response rate)<br><br>• 7 - Medical necessity documentations were submitted for continuing two benzos<br>• 10 - stated therapy will be changed so patient will only be on one benzo<br>• 2 - stated all benzos will be discontinued<br><br>86 Prior Authorization requests were received between 12/13/18 – 1/13/19.<br><br>60 have been approved<br><br>• 15 - Short term approval, asking for additional documentation and options (e.g. non-benzodiazepine drug for anxiety)<br>• 15 - Seizures, approved for one year<br>• 7 - Approved for one-year, long-term chronic patient<br>• 23 - One-time approval, request stated that one benzo will be discontinued<br><br>26 have been denied<br><br>• 14 - Currently on one benzo, request to add a second benzo was denied<br>• 8 - No documentation provided for two benzos,<br>• 2 - Both benzos prescribed for anxiety<br>• 2 - Request stated patient only on one benzo, but per PMP patient on second benzo prescribed by someone else. |

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| ➢ **Idaho Opioid Equivalent Dosing Project** | Mark England, Pharm.D. | **Slides 32 - 39**<br><br>Dr. England presented an update to the Idaho Opioid Equivalent Dosing Project to the Board.<br><br>Dr. England presented data from 4Q2018 to the Board and explained that the MME 90 edit was made operational on July 19, 2017. There was also quarterly data presented showing the trend from 1Q2017 through 4Q2018. There has been a 28% decrease from 1Q2017 to 4Q2018 in Members on Opioids and a 32% decrease in Opioid Members on > 90 MME during this same time period.<br><br>The Board reaffirmed Department priority efforts to focus on the front end of this issue before potential addiction and misuse becomes an issue. Dr. Brown is going to forward to Dr. Eide a recent study of Persistent Opioid Use Among Pediatric Patients After Surgery. |
| ➢ **Hepatitis-C DUR** | Chris Johnson, Pharm.D. | **Slides 40 – 52**<br><br>Dr. Johnson shared with the Board that HCV Prior Authorization Criteria was implemented beginning 5/13/2014 by the Idaho Medicaid P&T Committee. He then shared the timeline of the HCV criteria and specifically the liver fibrosis staging for which approval criteria has changed.<br><br>Dr. Johnson then presented data for approved claims from 2014 – 2018. The data included Demographics, HCV Genotypes, HCV Fibrosis Staging, HCV Agents, and Drug Costs broken down by specific agents as well as total costs paid out to pharmacies. |

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| | | There has been an increase in number of approvals since 2014 for several reasons. Fibrosis staging was adjusted from initial criteria of F3-F4 to current criteria of F0-F4 resulting in an increase in approvals by 49% from 2017 to 2018. Newer agent market approval and enhanced rebates resulted in more competitive pricing with a total cost decrease of 15% from 2017-2018.<br><br>Idaho Medicaid will continue prior authorizing and monitoring of this class of agents. |
| ➢ **Venlafaxine DUR** | Chris Johnson, Pharm.D. | **Slides 54 – 67**<br><br>The Idaho Medicaid Pharmacy & Therapeutics Committee requested an evaluation of the available evidence on cardiac safety with venlafaxine.<br><br>Dr. Johnson reviewed the mechanism of action of venlafaxine and the cardiac risks associated with the medication. He reviewed for the Board, a study that reported rare cases of QT prolongation with venlafaxine at therapeutic doses and in overdose. Currently newer SNRI's lack studies to review QT prolongation. There is a possible greater risk in patients with a history of cardiovascular disease especially in the elderly, concurrent use with other agents that may prolong QTc interval, higher doses or with renal or hepatic impairment.<br><br>Dr. Johnson then shared Medicaid utilization data from Oct-Dec 2018. There were 3730 total claims, 1332 total patients, and 748 total prescribers. The data reported 79 patients with venlafaxine doses greater than or equal to 300 mg/day. The breakdown includes 76 patients at 300 mg/day; 1 patient at 400 mg/day and 2 patients at 450 mg/day. |

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| | | In conclusion, there is limited evidence of venlafaxine and increased risk for cardiac adverse effects compared to other antidepressants. In the high dose population, there is a suggested potential increased risk of cardiac adverse effects; however, the data is limited and accuracy of the diagnoses in the medical system is dependent on the billing coder.<br><br>The Board suggested it may be beneficial to send educational letters to prescribers of high dose venlafaxine. |
| ➢ **clorazepate dipotassium tablets (Tranxene)** | Jane Gennrich, Pharm.D. | **Slides 68 - 79**<br><br>Dr. Gennrich presented the FDA approved indications, dosage, and pharmacokinetics of clorazepate dipotassium tablets. She shared the previous quantities per day allowed by Idaho Medicaid and the new quantities per day as of 12/3/2018.<br><br>Paid claims between 8/25/18 – 11/25/18 were reviewed. There were 23 unique patients, 59 paid claims for an average of 2.6 claims/patient. Breakdown of daily mg dose across the patients was presented and some patient specific examples were provided for the Board to discuss. |
| ➢ **chlordiazepoxide (Librium)** | Jane Gennrich, Pharm.D. | **Slides 80 - 87**<br><br>Dr. Gennrich presented the FDA approved indications, and adults usual daily dose for the specific indications. She shared the previous quantities per day allowed by Idaho Medicaid and the new quantities per day as of 12/3/2018.<br><br>Paid claims between 8/27/18 – 11/27-18 were reviewed. There were 39 unique patients and 57 paid claims. Breakdown of the number of paid claims/patients were presented with specific |

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| | | examples of 9 patients with > 1 claim. No current patients are getting more than 4 capsules daily, so no one will be affected by decreasing the quantity of capsules per day allowed from six to four. |
| ➢ **chlordiazepoxide/clindinium (Librax)** | Jane Gennrich, Pharm.D. | **Slides 88 - 91**<br><br>Dr. Gennrich presented the FDA approved indications and usual daily dose. She shared the previous quantities per day allowed by Idaho Medicaid and the new quantities per day as of 12/3/2018.<br><br>There were no paid claims for chlordiazepoxide/clidinium between 8/27/18 – 11/27/18. |
| ➢ **chlordiazepoxide/amitriptyline (Limbitrol)** | Jane Gennrich, Pharm.D. | **Slides 92 - 95**<br><br>Dr. Gennrich presented the FDA approved indications and usual daily dose. She shared the currently allowed doses and they are already below FDA approved dosing so no quantity changes were needed.<br><br>There were no paid claims for chlordiazepoxide/clidinium between 8/27/18 – 11/27/18. |
| ➢ **alprazolam (Xanax)** | Jane Gennrich, Pharm.D. | **Slides 96**<br><br>Dr. Gennrich shared that the next benzodiazepine scheduled to be reviewed and quantity reduction made was going to be alprazolam. |
| ➢ **Butalbital Migraine Medications** | Jane Gennrich, Pharm.D. | **Slides 97 - 112** |

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| | | An unsolicited e-mail from a local neurologist concerned about patients receiving butalbital containing migraine medications triggered this review. The email stated that the butalbital compounds were the #1 cause of medication overuse headache and he had been seeing high numbers of medication overuse headaches in the Treasure Valley and was hoping to work with Idaho Medicaid in changing policies surrounding these medications.<br><br>Dr. Gennrich presented information on: What do doctors mean by 'Medication Overuse Headache'?, Why can frequent use of pain medications cause more headaches?, What is the treatment for Medication Overuse Headache?, and Why do we need to be wary of Medication Overuse Headache?.<br><br>Dr. Gennrich presented information on the Indications and Usage, Dosage and Administration, and Drug Abuse and Dependence from the product labeling for butalbital/acetaminophen/caffeine. Idaho Medicaid currently has no prior authorization requirement for patients to receive butalbital/acetaminophen/caffeine or butalbital/aspirin/caffeine medications. Prior authorization is currently required for narcotic containing medications with butalbital. Therapeutic criteria are trial and failure (or contra-indication) to a non-narcotic migraine treatment medication (e.g. triptan or NSAID).<br><br>Data on patients with paid claims for butalbital containing migraine medications between 11/16/17 – 11/15/18 was presented. There were a total of 1,034 patients, 2,749 claims and 635 prescribers.<br><br>Dr. Gennrich then presented reviewed paid claims between 10/1/18 – 12/31/18 for butalbital 50mg/acetaminophen 325mg/caffeine 40mg tablets specifically. 130 patients (61%) had |

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| | | only one fill in a three month time period and 46 patients (22%) are being prescribed this medication daily – which predisposes them to medication overuse headaches.<br><br>Dr. Gennrich had a phone discussion on 1/2/19 with the local neurologist and multiple steps were proposed moving forward:<br><br>1. Require prior authorization for NEW patients starting on butalbital containing migraine medications<br><br>• Therapeutic criteria will be trial and failure (or contra-indication) to all triptans, multiple NSAIDS, and acetaminophen.<br><br>• If approved (which should occur rarely), limit to 12 tablets monthly.<br><br>2. For current patients, send out educational DUR letter with referenced information on Medication Overuse Headaches as well as tapering suggestion.<br><br>• Suggestion from Dr. Smith for tapering plan – reduce by one tablet daily every week so if on medication three times daily, reduce to twice daily for one week, then once daily for one week, then discontinue drug.<br><br>• Put in prior authorization approvals for current patients for 3 months to allow time |

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| | | for prescriber to read and react to DUR letter.<br><br>The Board recommended it may be useful to investigate the history of the members who are using these medications on a consistent monthly basis. |
| ➢ **Typical Antipsychotic Use in Children** | Chris Johnson, Pharm.D. | **Slides 113 – 124**<br><br>This request came from the July 19, 2018 Idaho DUR Board meeting. In a DUR from that meeting looking at all antipsychotics it was noted there were 33 claims for typical antipsychotic agents for patients 5 to 10 years of age. The Board expressed concerns that typical agents were being prescribed to this subset of children, and questions as to why.<br><br>Dr. Johnson presented a review of all claims from Oct-Dec 2018 with ages less than or equal to 10 y/o for typical antipsychotics. A total of 9 patients (7 male and 2 female) were evaluated for the reported period.<br><br>Dr. Johnson then presented the claim and diagnosis data on each patient as well as any chart notes he was able to obtain.<br><br>In conclusion, typical antipsychotic drug utilization in children less than or equal to 10 years of age is low. Haloperidol is the most common agent used for controlling severe aggression/violent behavior which is FDA approved for ages 3 to 12. Pimozide was used for FDA approved treatment of "Tic Disorder/ Tourette's Syndrome and chlorpromazine for FDA approved treatment of "Problem Behavior (Severe)". Providers were specialists in child/adolescent psychiatry. |

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| ➢ **Study Proposals for Next Quarter** | Mark England, Pharm.D. | **Slide 125 - 126**<br><br>Potential studies for upcoming DURs include:<br><br>• Idaho Medicaid Patients Paying Cash for Controlled Substances (Is it possible to provide list of Medicaid Members to see who have paid cash through the PDMP?)<br>• Concomitant use of Opioids and Benzodiazepines<br>• Drug Spend/Utilization of Cytokine and CAM Antagonists<br>• Look at Members < 5 and between 5 – 10 y/o on all antipsychotic medications |
| ➢ **ProDUR Quarterly Report** | Mark England, Pharm.D. | **Slides 127 - 128**<br><br>Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted. |
| ➢ **Medicaid Update** | Tami Eide, Pharm.D. | **Slide 129**<br><br>Dr. Eide shared there is a new IDHW Director, David Jeppesen. |
| ➢ **Adjourn, 12:00pm** | Mark Randleman, D.O. | |

**Next Meeting: April 18, 2019**