Idaho DUR Board Meeting Minutes

Date: April 18, 2019 **Time:** 9am-12:30pm

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

Moderator: Mark Randleman, D.O.

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

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

[☆]Magellan Rx Management

AGENDA ITEMS	PRESENTER	OUTCOMES/ACTIONS
➢ **Call to Order**	Mark Randleman, D.O.	Dr. Mark Randleman called the meeting to order.  DUR_4_18_2019_Final(2).pdf
➢ **Review of Minutes from January 17, 2019**	Mark Randleman, D.O.	Minutes were approved as written.
➢ **Foster Children and Behavioral Health Drugs**	Tami Eide, Pharm.D.	**Slides 2 – 20** 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 2018 data was presented. Overall rates for Foster Children with a Behavioral Health Medication was 17.5% and for Non-Foster Children it was 7.1%. These percentages have decreased slightly over the past few years. For 2018, a higher percentage of foster children received ADHD, antianxiety and sedative hypnotic, anticonvulsants, miscellaneous, antidepressants, antimanic and antipsychotic agents than non-foster children. 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 – 2.56 vs. 0.81. The cost per foster child was also substantially higher at $184 vs. $73 non-foster. The following is a breakdown by % of claims by prescriber type for foster children: Nurse Practitioner – 38% Child/Adolescent Psychiatrist/Developmental Specialist – 13% Pediatrician – 13% Physician Assistant – 12% Psychiatrist – 10% Family Practice/Internal Medicine – 12%

		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.
➢ **Uloric Update**	Jane Gennrich, Pharm.D.	**Slides 22 – 25** Dr. Gennrich shared with the Board the FDA Safety Announcement from 2-21-2019 that added a Boxed Warning for increased risk of death with gout medicine Uloric (febuxostat). Dr. Gennrich then shared the updated Antihyperuricemics PA Form with the DUR Board.
➢ **Two or more benzodiazepines**	Jane Gennrich, Pharm.D.	**Slides 26 – 32** 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). DUR Letters informing current prescribers of this new prior authorization requirement were sent out ahead of time. 86 Prior Authorization requests were received between 12/13/18 – 1/12/19. 60 have been approved

		• 15 - Short term approval, asking for additional documentation and options (e.g. non-benzodiazepine drug for anxiety) • 15 - Seizures, approved for one year • 7 - Approved for one-year, long-term chronic patient • 23 - One-time approval, request stated that one benzo will be discontinued 26 have been denied • 14 - Currently on one benzo, request to add a second benzo was denied • 8 - No documentation provided for two benzos, • 2 - Both benzos prescribed for anxiety • 2 - Request stated patient only on one benzo, but per PMP patient on second benzo prescribed by someone else. 89 Prior Authorization requests were received between 1/13/19 – 2/12/19. 61 have been approved • 8 - Short term approval, asking for additional documentation and options (e.g. non-benzodiazepine drug for anxiety) • 10 - Seizures, approved for one year • 4 - Approved for one-year, long-term chronic patient • 36 - One-time approval, request stated that one benzo will be discontinued

		• 3 – One-time pre-procedure benzodiazepine in addition to regularly prescribed benzodiazepine 18 have been denied • 13 - Currently on one benzo, request to add a second benzo was denied • 2 - No documentation provided for two benzos, • 3 - Both benzos prescribed for anxiety
➢ **Butalbital Migraine Medications**	Jane Gennrich, Pharm.D.	**Slides 34 – 42** 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. Dr. Gennrich presented information on: What do doctors mean by 'Medication Overuse Headache'? 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 is a trial and failure (or contra-indication) to a non-narcotic migraine treatment medication (e.g. triptan or NSAID).

		Data on patients with paid claims for butalbital containing migraine medications between 11/16/17 – 11/15/18 was presented. There was a total of 1,034 patients. Dr. Gennrich also reviewed paid claims between 10/1/18 – 12/31/18 for butalbital 50mg/acetaminophen 325mg/caffeine 40mg tablets specifically. 130 patients (61%) had 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. Dr. Gennrich had a phone discussion on 1/2/19 with the local neurologist and multiple steps were proposed moving forward: 1. Require prior authorization for NEW patients starting on butalbital containing migraine medications • Therapeutic criteria will be trial and failure (or contra-indication) to all triptans, multiple NSAIDS, and acetaminophen. • If approved (which should occur rarely), limit to 12 tablets monthly. 2. For current patients, send out educational DUR letter with referenced information on Medication Overuse Headaches as well as tapering suggestion. • Suggestion 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. On March 14, 2019, 141 letters were sent out to prescribers of 156 identified members. A copy of the letter was provided to the DUR Board Members. The letter stated that beginning July 1, 2019 (which has since been amended to June 1st, 2019 start) all butalbital containing medications will require prior authorization with documentation as to why a different abortive medication (e.g. triptan, NSAID) cannot be used. For new patients approved for butalbital containing medications, a maximum of 12 tablets/30 days will be allowed without a quantity override prior authorization with medical necessity documentation.
➢ **Idaho Opioid Equivalent Dosing Project**	Mark England, Pharm.D.	**Slides 43 – 50** Dr. England presented an update to the Idaho Opioid Equivalent Dosing Project to the Board. Dr. England presented data from 1Q2019 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 1Q2019. There has been a 30% decrease from 1Q2017 to 1Q2019 in Members on Opioids and a 36% decrease in Opioid Members on > 90 MME during this same time period. On-going work is being done to focus on the front end of this issue before potential addiction and misuse becomes an issue. Dr.

		England and Dr. Eide are currently reviewing data from CY2018 which has identified opioid new starts and hope to have a report back for the July DUR Meeting.
➢ **Epidiolex**	Chris Johnson, Pharm.D.	**Slides 51 – 61** Dr. Johnson shared with the DUR Board that Epidiolex was FDA approved on June 5, 2018 and it is the first drug comprised of an active ingredient derived from the cannabis sativa plant for the treatment of rare/severe forms of epilepsy- Lennox-Gestaut Syndrome and Dravet Syndrome. The FDA has classified it as a Schedule V controlled substance. It is a major component found in cannabis, but does not produce euphoric effects known with tetrahydrocannabinol (THC). It is also not the same as cannabidiol oil (CBD oil) sold by private dispensaries. Dr. Johnson shared with the DUR Board comments from the November 2018 P&T Committee Meeting by Dr. Robert Wechsler's from the Idaho Comprehensive Epilepsy Center. Dr. Johnson reported that there were 3 placebo-controlled PIVOTAL Trials for Epidiolex. He reviewed safety concerns, drug interactions and issues with administering with a high fat meal. Dr. Johnson then presented utilization data of Epidiolex in Idaho Medicaid from 6/25/2018 through 4/4/2019. He shared the demographics of the 65 Idaho Medicaid patients who were approved for Epidiolex use. The mean age of users was 15 years old. He also reviewed other anticonvulsant claims data during this same time from these members, diagnosis data obtained, provider specialty, and denied claims information. It was noticed that dosing in these patients is higher than that of the trial patients. In conclusion, Epidiolex® utilization appears to be prescribed by neurologists specializing in epilepsy disorders, all patients have a

		history of anticonvulsants prior, and were approved for the FDA approved indications for Lennox-Gestaut Syndrome and Dravet Syndrome. There were only a few prior authorization requests for off-label use (e.g. mood disorder) and these were denied.
➢ **PCSK9 Inhibitors**	Chris Johnson, Pharm.D.	**Slides 62 – 73** Dr. Johnson shared that the 2018 ACC/AHA Guideline on the Management of Blood Cholesterol allows for more personalized care for patients. It emphasizes a healthy lifestyle to reduce atherosclerotic cardiovascular disease (ASCVD) risk at all ages. He then presented patient treatment for both primary and secondary prevention. Dr. Johnson reviewed the mechanism of action of PCSK9's within the body and reviewed the appropriate place in therapy for Praluent and Repatha. He also shared the current Idaho Medicaid Prior Authorization criteria. Utilization for these agents from 1/1/2019 – 3/31/2019 included 5 Idaho Medicaid members. Dr. Johnson reviewed the ICD-10 diagnoses, other hyperlipidemic drugs, and pre and post PCSK9 LDL-C numbers of these members. In conclusion, there is limited utilization within Idaho Medicaid, all patients have a history of adverse effects to statins (rather than failure), all had diagnosis of hyperlipidemia with ASCVD; however, patients had not met the 2018 ACC/AHA Guideline goal of less than or equal to 70 mg/dl in patients with ASCVD.

➢ **Targeted Immune Modulators**	Tami Eide, Pharm.D.	**Slides 75 – 102** Dr Eide first presented a chart breakdown of Anti-Tumor Necrosis Factor (TNF) Biologics, Other Biologic Agents, and Non-Biologic Agents classified as targeted immune modulators. She then presented the specific indications of these products for Rheumatoid Arthritis and/or Ankylosing Spondylitis, Plaque Psoriasis and/or Psoriatic Arthritis, Inflammatory Bowel Disease (Ulcerative Colitis/Crohn's Disease), Select Periodic Fever Syndromes, Hidradenitis Suppurativa, Uveitis and Cytokine Release Syndrome. Dr. Eide then provided an overview of the cellular mechanisms of these agents and subsequently the place in therapy for each for the individual diseases for which these drugs are indicated. After this background information was provided Dr. Eide provided the DUR Board with the current preferred list and current criteria for these agents and detailed utilization patterns for the time period of 3/1/2018 – 2/18/2019. • Humira had the most claims and number of patients followed by Enbrel. • There was over $15 Million in total expenditures for these drugs which represented 6.8% of total and 1.8% of net expenditures of all Medicaid Pharmacy claims over this time period. • In terms of cost per claim, Taltz came out the highest, followed by Stelara and Tremfya. • Dr. Eide provided a breakdown of the number of patients by diagnosis, patients with multiple diagnoses, and number with unknown diagnosis. Those with unknown diagnosis were further broken down by type of prescriber to ascertain the probable reason for the medication.

		• The DUR Board suggested sending letters to the prescribers of the 26 members with unavailable diagnoses in their electronic profiles as well as exploring the potential of creating an Auto PA with diagnosis.
➢ **Alprazolam Quantity DUR**	Jane Gennrich, Pharm.D.	**Slides 103 - 113** Dr. Gennrich presented the FDA approved indications and duration of therapy for alprazolam. She then shared with the Board the NICE Guidelines for Treatment of Generalized Anxiety Disorder (GAD) from the National Institute of Health and Care Excellence, England. Dr. Gennrich shared the previous quantities per day allowed by Idaho Medicaid and the new quantities per day as of 2/25/2019. On this date the quantity allowed was changed to three tablets daily. 119 Patients were identified as having received more than 3 tablets daily between 10/27/2018 and 1/27/2019. At the time of review, 65 filled less than 90 tablets monthly, 15 were no longer on > 90 tablets monthly, 32 were on 3.1-4 tablets daily, and 7 were on > 4 tablets daily. For patients on 3.1 to 4 tablets daily, a quantity override PA was pro-actively entered for one year. For those members over 4 tablets daily, a fax was sent to the prescribers letting them know the maximum quantity was going to be changing to 3 tablets daily and that a PA with medical necessity justification would need to be submitted to continue this course of therapy. • Dr. Gennrich shared with the Board the 4 PA requests she had received so far.

➢ **ADURS – American Drug Utilization Review Society**	Jane Gennrich, Pharm.D.	**Slides 114 – 128** • Dr. Gennrich provided slides and an overview of the 2019 Symposium she attended on February 21-23 in Scottsdale, Arizona. The topics included the Opioid Epidemic and Treatment; Days' Supply Limit of Benzodiazepines in Oregon; Migraine Medications; Physician Administered Drugs; Decreasing Antipsychotic Prescribing in Oppositional Defiant Disorder; Hemophilia Treatment; Cell and Gene Therapies; Value Based Pricing Models, and a Drug Pipeline Preview.
➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	**Slide 129** Two suggested topics included Xeljanz use and side effects and looking deeper into anxiety and if agents other than benzodiazepines had been tried in Idaho Medicaid Members who were currently on a benzodiazepine.
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	**Slides 130 - 131** Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	**Slide 132** Dr. Eide shared with the DUR Board what she knew at this time about the upcoming 1/1/2020 Medicaid Expansion Group.

➢ **Adjourn, 12:30pm**	Mark Randleman, D.O.	

Next Meeting: July 18, 2019