# Idaho DUR Board Meeting Minutes

**Date:** July 18, 2019 **Time:** 9am-12:00pm

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

**Moderator:** Magni Hamso, M.D.

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

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

[☆]Magellan Rx Management

| AGENDA ITEMS | PRESENTER | OUTCOMES/ACTIONS |
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| ➢ **Call to Order** | Tami Eide, Pharm.D. | Dr. Tami Eide, called the meeting to order.<br>  <br>DUR_7_18_2019_Final_V2.pdf |
| ➢ **Review of Minutes from April 18, 2019** | Tami Eide, Pharm.D. | Minutes were approved as written. |
| ➢ **DUR Annual Report - Highlights** | Tami Eide, Pharm.D. | **Slides 2 – 20**<br><br>Dr. Eide began by giving the background on why the DUR program exists. She then highlighted the 11 sections and 8 attachments that were submitted to complete the Annual Report. One question that stood out this year was: Do you receive and review follow-up on periodic reports providing individual pharmacy provider DUR alert |

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| | | override activity in summary and/or in detail? And If you receive reports, do you follow up with those providers who routinely override with interventions ? Contact Pharmacy ? Refer to Program Integrity for Review? She noted that this was something we should probably look at doing in the future.<br><br>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 highlighted some of the changes in drug utilization and PA requests that differed from the previous year. |
| ➢ **Follow-up to Previous Reviews** | | |
| • Butalbital DUR | Jane Gennrich, Pharm.D. | **Slides 22 – 42**<br><br>A question was asked at the April 2019 DUR Meeting, What medications can be safely used to treat migraines during pregnancy?<br><br>Dr. Gennrich explained that the A, B, C, D and X pregnancy risk categories, in use since 1979, have now been replaced with narrative sections on pregnancy, lactation, and fertility. She explained in detail the difference between the old and new categories. She then gave the specific details on butalbital, rizatriptan, and diclofenac for pregnancy and lactation.<br><br>Dr. Gennrich shared the American Migraine Foundation's and Association of Migraine Disorders' recommendations for the |

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| | | treatment of migraines in pregnancy with acetaminophen being the initial drug of choice. |
| ➢ **Ongoing Reviews** | | |
| • Idaho Opioid Equivalent Dosing Project | Mark England, Pharm.D. | **Slides 44 – 58**<br><br>Dr. England presented an update on the Idaho Opioid Equivalent Dosing Project to the Board.<br><br>Dr. England presented data from 2Q2019 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 2Q2019. There has been a 31% decrease from 1Q2017 to 2Q2019 in Members on Opioids and a 37% decrease in Opioid Members on > 90 MME during this same time period.<br><br>The DUR Board requested to see if the members with the highest MMEs have received a naloxone prescription. |
| ➢ **Current Interventions/Outcomes Studies** | | |
| • Injectable Testosterone DUR | Jane Gennrich, Pharm.D. | **Slides 60 – 71**<br><br>During the April 2019 P&T Committee meeting it was pointed out that topical androgenic agents require prior authorization, but that most injectable testosterone products did not. The committee requested that a utilization review be done by the DUR Board, looking at injectable testosterone. |

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| | | Dr. Gennrich discussed FDA indications and Micromedex compendia favoring use of the enanthate, cypionate, and undecanoate forms of testosterone. She reviewed the PA requirements and typical reimbursement for the products on both the outpatient (Rx) and physician administered drug (PAD) side for these agents as well as serious potential side effects.<br><br>Paid Claims analysis was provided for both Rx and PAD between 4/1/2018 and 3/31/2019.<br><br>The recommendations which the DUR Board agreed with were:<br><br>1. Continue to NOT require prior authorization for injectable testosterone cypionate or testosterone enanthate.<br>2. Continue to require prior authorization for injectable testosterone undecanoate because of higher risk and cost than therapeutically equivalent products.<br><br>The DUR Boards' only request was to investigate the utilization of the 10ml vs 1 ml vial of testosterone cypionate. |
| • Alprazolam DUR | Jane Gennrich, Pharm.D. | **Slides 72 – 87**<br><br>The purpose of this review was to evaluate patients on alprazolam, presumably for treatment of anxiety, who are not concurrently on any SSRI, SNRI, hydroxyzine, or buspirone for anxiety treatment.<br><br>Patients were selected who had paid claims between 5/7/2018 and 5/6/2019 for alprazolam, but who had no paid claims for any SSRI, SNRI, buspirone, or hydroxyzine in the previous 365 days. These patients were receiving alprazolam as follows.<br><br>>= 2 claims for alprazolam in 90 days: n=223<br>>= 3 claims for alprazolam in 90 days: n=159 |

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| | | >= 6 claims for alprazolam in 183 days: n=125<br><br>Dr. Gennrich reviewed 63 patients (half of the 125 patients identified) for number of tablets per day, dose (mg/day), and duration of alprazolam therapy.<br><br>• Patients received 1-6 tablets per day with an equal split between 1, 2 or 3 tablets per day.<br>• Dose per day ranged from 0.25– 8 mg/day, with the highest number receiving 3 mg/day.<br><br>Dr. Gennrich reviewed package insert statement on length of therapy for alprazolam which states: "Demonstrations of the effectiveness of XANAX by systematic clinical study are limited to 4 months duration for anxiety disorder and 4 to 10 weeks duration for panic disorder; however, patients with panic disorder have been treated on an open basis for up to 8 months without apparent loss of benefit. The physician should periodically reassess the usefulness of the drug for the individual patient."<br><br>Dr. Gennrich then presented the prescriber breakdown by MD, NP or PA and if MD their actual specialty; number of patients per prescriber and other psychiatric diagnoses in electronic profile. She then focused on concomitant opioid use as well as those also paying cash for additional controlled substances.<br><br>The Board recommended potentially targeting prescribers who have patients on higher doses as well as identifying those patients on more than 3 per day concurrent with opioids. |
| • Tramadol Utilization & Review | Magni Hamso, M.D. and Chris Johnson, Pharm.D. | **Slides 88 – 113** |

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| | | The question raised by the Idaho Pharmacy and Therapeutics Committee was: Does tramadol pose significant risk of addiction and/or overdose compared to other short-acting opioids?<br><br>Dr. Hamso reviewed a cohort study that was published in the British Medical Journal in May of 2019 that looked at the chronic use of tramadol after an acute pain episode. She presented the study population and design, and then detailed the results of this study which showed a higher risk with tramadol than other opioids.<br><br>Dr. Hamso then reviewed a study from the Journal of the American Medical Association which looked at the association of tramadol with all-cause mortality among patients with osteoarthritis that was published in March 2019. She presented the study population and design and detailed the results of this study which showed a higher mortality for tramadol vs NSAIDs at 1yr follow-up, a similar mortality to codeine, and mortality rates from CVD, GI, infectious, cancer, respiratory diseases all higher for tramadol vs NSAIDs, BUT not statistically significant.<br><br>Dr. Hamso then reviewed a study published by the Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report from March 17, 2017: Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use – United States, 2006-2015. She presented the study population and design and detailed the results of this study which showed the probability of long-term opioid use increases sharply even after a few days of opioid use. Opioid use at 1 year was 13.5% for those whose first episode of use was >= 8 days, 29.9% for >=31 days. It also showed the probability of long-term opioid use also increases with refills. Tramadol specific results showed probability of use at 13.1% at 1yr and 6.8% at 3yrs and among patients who initiated tramadol, >64% who continued opioid use beyond 1yr were still on tramadol – perhaps intentionally treated for chronic pain management. |

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| | | In summary looking at these studies:<br><br>• Tramadol use, like other opioid use, increases the risk of chronic use (addiction?) and death<br>• There may be a slightly higher risk of long-term use with the use of tramadol compared to other short-acting opioids after surgery<br>• The data is limited and observational only<br>• There is likely not enough information to change how we manage tramadol, other than considering it as high risk like any other opioid.<br><br>Dr. Johnson then presented tramadol utilization in the Idaho Medicaid Population from 2nd quarter 2019. He covered demographics, total claims, utilizers, and then analyzed in further detail just tramadol IR as there was very limited use of tramadol/apap and tramadol ER. Dr. Johnson then reviewed all claims of this subset from 1/1/2019 to 7/16/2019 for these members. He presented the number of members with concomitant opioid analgesic claims, historical tramadol trends and overall short and long acting opioid claims.<br><br>In conclusion<br><br>• Tramadol IR utilization appears to be decreasing<br>• 77% of tramadol IR claims are for women<br>• There is minimal concomitant use of other opioids<br>• The research is limited, and studies are observational based on claims data, but do suggest that tramadol is at least as risky as other opioids,<br>• Given decreasing utilization and limited research, there is likely no need to change preferred status or add PA to tramadol at this point. |

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| • Opioid Use Disorder | Chris Johnson, Pharm.D. | **Slides 114 – 124**<br><br>This review was requested by the Idaho Pharmacy and Therapeutics Committee and consisted of two questions:<br><br>• How many Medicaid clients are on active Medication-Assisted Treatment (MAT)?<br><br>• How many Medicaid clients have a diagnosis of opioid use disorder?<br><br>Dr. Johnson reviewed data from April to June 2019. He pulled Medicaid members with active buprenorphine/naloxone (BUP/NAL) and or buprenorphine (BUP) claims and/or ICD-10 diagnosis codes (F11.xx) for opioid related disorders.<br><br>Results showed 90% of members with opioid use disorder had no MAT and 10% had active MAT. Dr. Johnson then broke down the 10% by gender, age, and total claims. He then presented unique members by geographic region in the State of Idaho.<br><br>In conclusion:<br><br>• Approximately 577 (10%) Medicaid clients with an opioid used disorder diagnosis based upon ICD-10 coding for Opioid Related Disorders are on MAT.<br>• Most patients with ICD-10 coding for Opioid Related Disorders are located in Regions 1, 3, and 4.<br><br>Limitations to data:<br><br>• Billing codes may not be accurate. Potential for incorrect coding for chronic pain or cancer pain. |

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| | | • Methadone treatment for opioid use disorder is not available through outpatient pharmacy services. |
| ➢ **Study Proposals for Next Quarter** | Mark England, Pharm.D. | **Slide 125**<br><br>Suggested proposals included opioids and gabapentin, gabapentin and indications, NOAC anticoagulants – initial vs. chronic dosing. |
| ➢ **ProDUR Quarterly Report** | Mark England, Pharm.D. | **Slides 126 - 127**<br><br>Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted. |
| ➢ **Medicaid Update** | Tami Eide, Pharm.D. | **Slide 128**<br><br>Dr. Eide shared with the Board plans for upcoming Medicaid Expansion, Medicaid's work with prescribers as it relates to controlled substances and cash paying customers and how it will take a patient centered approach moving forward. |
| ➢ **Adjourn, 12:30pm** | Magni Hamso, M.D. | |

**Next Meeting: October 17, 2019**