Idaho DUR Board Meeting Minutes

Date: January 16, 2020 **Time:** 9am-12:00pm

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

Moderator: Christine Hahn, M.D.

Committee Member Present: Sabrina Allen, Pharm.D., Wayne Baures, RPh, Dawn Berheim, Pharm.D., Perry Brown, M.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
➢ **Call to Order**	Christine Hahn, M.D.	Dr. Christine Hahn called the meeting to order.  DUR_1_16_2020_Final (2).pdf
➢ **Review of Minutes from October 17, 2019**	Christine Hahn, M.D.	Minutes were approved as written.
➢ **Support Act Updates**	Tami Eide, Pharm.D.	**Slides 2 – 13** Dr. Eide gave an update to the DUR Board required implementation dates as they related to the SUPPORT ACT, Section 1004 Specific to State Medicaid DUR Programs.

		• Strategies included are required to be implemented by October 1, 2019 • State Plan Amendment required to be submitted to CMS by December 31, 2019 • Reports to Congress with information from states' federal fiscal year 2020 DUR Reports Dr. Eide noted that Idaho's State Plan amendment was submitted January 7, 2020 to CMS for approval. Dr. Eide gave specific details on 4.26 K. (Claims Review Limitations), 4.26 L. (Program to Monitor Antipsychotic Medications by Children), 4.26 M. (Fraud and Abuse Identification). She provided the DUR Board a handout that outlined Idaho Medicaid activities that detailed how Idaho Medicaid will comply with SUPPORT ACT requirements for Medicaid DUR Programs. Dr. Eide shared with the DUR Board Idaho's submission to CMS for a SUPPORT ACT Grant centered around effective PDMP utilization. A section of the SUPPORT Act requires states to monitor concurrent prescribing of opioids, perform drug utilization reviews for opioid refills, and monitor antipsychotic prescribing for children. The bill also requires Medicaid providers to check prescription drug monitoring programs (PDMPs) before prescribing controlled substances. In May, CMS provided information to states about claiming the 100 percent federal Medicaid matching funds for certain expenditures related to qualified PDMPs described in section 1944(f). As part of this overall grant, the Pharmacy Unit has included two temporary (contract) clinical pharmacist positions. Dr. Eide reviewed details of the roles and responsibilities these two individuals will have. At the end of the grant year, the plan is for these pharmacists to evaluate and justify continuation of their

		positions after analysis of prescribing practice changes, clinical outcome evaluations, and cost avoidance/savings.
➢ **Medicaid Expansion**	Tami, Eide, Pharm.D.	**Slides 14 – 22** Dr. Eide provided a handout to the DUR Board that is referred to as the "Pharmacy 101" document. It has details on Idaho Medicaid Drug Coverage specific to: Preferred Drug List, Non-preferred drugs, Drugs Requiring Prior Authorization, Drug Supply Quantities, and Physician Administered Drugs. Also included on this handout are the links to several useful website pages and documents that give even more detail. Dr. Eide shared with the DUR Board the predicted increases to Drug Utilization that the Medicaid Expansion Population will bring to Idaho Medicaid. Increased utilization is expected in the following drug classes: Angiotensin Modulators, Antidepressants, Antipsychotics, Benzodiazepines, Calcium Channel Blockers, Diuretics, Hepatitis C, HIV, Neuropathic Pain, NSAIDs, Opiate Dependence Treatments, Opioids, and Statins. Through 1/14/2020, approximately 56,000 enrollees have accounted for 49,218 paid claims at a total paid amount of $1,335,694.
➢ **Ongoing Reviews**		
• Idaho Opioid Equivalent Dosing Project	Mark England, Pharm.D.	**Slides 24 – 39** Dr. England presented an update on the Idaho Opioid Equivalent Dosing Project to the DUR Board. He reviewed the methods that

		the IDHW Pharmacy Unit is managing opioid utilization and noted that the MME 90 edit was made operation on July 19, 2017. Dr. England presented data from 4Q2019 to the Board. There was also quarterly data presented showing trends from 1Q2017 through 4Q2019. There has been a 37% decrease from 1Q2017 to 4Q2019 in Members on Opioids and a 39% decrease in Opioid Members on > 90 MME during this same time period. Additional information was provided on the concomitant use of opioids and benzodiazepines and concomitant use of opioids and antipsychotics. More detailed data was also shown on the number of members on concomitant opioids > 90 MME with antipsychotics.
➢ **Current Interventions/Outcomes Studies**		
• Vimpat (lacosamide)	Jane Gennrich, Pharm.D.	**Slides 41 – 55** Dr. Gennrich shared the Warnings and Precautions from the Vimpat prescribing information, specifically Cardiac Rhythm and Conduction Abnormalities: Obtaining ECG before beginning and after titration to steady-state maintenance is recommended in patients with underlying proarrhythmic conditions or on concomitant medications that effect cardiac conduction. Dr. Gennrich shared Idaho Medicaid specific data looking at paid claims between 9/1/2019 and 11/30/2019. 222 patients were identified, of which 9 patients had a cardiac abnormality identified in their medical diagnosis history. There were 5 males and 4 females. Six of the nine had their Vimpat prescribed by a neurologist. None of these nine had seen a cardiologist in the previous year.

		Dr. Gennrich then reviewed the warnings surrounding the concomitant medications that affect cardiac conduction, as well as the recommendation that patients should obtain an ECG before beginning VIMPAT, and after VIMPAT is titrated to steady-state. In reviewing the same subset of patients, 113 were identified without an ICD-10 code in their electronic profile for cardiac conduction abnormalities to review more intensely. Of these, 16 were on beta blockers, 1 on a calcium channel blocker, 1 on a beta blocker and calcium channel blocker, and 95 were not on a beta blocker OR calcium channel blocker. The DUR Board recommended sending a DUR Letter to the PCP and/or neurologist with safety information on prescribing Vimpat (lacosamide) to patients with a cardiac rhythm or conduction abnormalities and those who had a patient on concomitant beta blockers and/or calcium channel blockers.
• Clonazepam	Chris Johnson, Pharm.D.	**Slides 56 – 65** At the November Idaho Medicaid P&T Committee the members requested that the Department evaluate the percentage of clonazepam use for seizure disorders vs other indications. Dr. Johnson shared that clonazepam is FDA approved for absence seizures, Lennox-Gastaut syndrome, myoclonic seizures, panic disorder, and akinetic seizures. Non-FDA indications include burning mouth syndrome, sleep walking disorder, and social phobia. All clonazepam claims from 8/1/2019 to 10/31/2019 were reviewed and the following ICD-10 diagnosis codes for these patients were reviewed: Diseases of the Nervous System (G00-G99); G40.XX

		Epilepsy and recurrent seizures and G80.XX Cerebral palsy and other paralytic syndromes.
		
		Dr. Johnson shared the following results:
		
		• Total clonazepam utilization (3rd Qtr. 2019)
		  • 1,257 unique clients.
		  • 3,087 total claims.
		  • 72% female and 28% male.
		• Clonazepam utilization with ICD-10 codes related to seizures or epilepsy.
		  • 278 unique clients (22% of total unique clients).
		  • 729 claims (24% of total claims).
		  • 65% female and 35% male.
		
		The DUR Board recommended that further investigation into the non-epilepsy uses is warranted as part of further activities related to improving benzodiazepine use.

• Rectal Diazepam	Chris Johnson, Pharm.D.	**Slides 66 – 76** Dr. Johnson reviewed rectal diazepam utilization for the management of refractory epilepsy in the Idaho Medicaid population. He noted that diazepam rectal gel is a gel formulation indicated for rectal administration in the management of refractory patients with epilepsy on stable regimens of anti-epileptic drugs who require intermittent use of diazepam to control bouts of increased seizure activity. He also noted that is recommended that

		diazepam rectal gel be used to treat no more than five episodes per month and no more than one episode every five days. Current quantity limit in Idaho Medicaid is 1 unit per day. Dr. Johnson reviewed rectal diazepam claims from Jan 1, 2019 to Dec 31, 2019 and found 293 total unique clients with 624 total claims. He then reviewed demographic information for gender and age, number of claims by month and how many units dispensed. Participants who had high a high frequency of doses dispensed were evaluated for prescribing appropriateness. In conclusion, rectal diazepam utilization is consistent with expected participant population with most claims dispensed for ages 0-20 years. Seven percent of total claims exceeded more than 2 units per claim which patient chart reviews supported were justified use for seizure diagnoses. The DUR Board recommended two further activities. They asked that a comparison of rectal diazepam use with the newly approved intranasal midazolam (Nayzilam) be done in 9 months. They also recommended that an educational outreach be done for those participants that appeared to be outliers based on the number of claims and/or units of rectal diazepam per claim.
• Benzodiazepines AND Opioids	Jane Gennrich, Pharm.D.	**Slides 77 – 87** Dr. Gennrich presented utilization data looking at paid claims from 9/1/2019 to 11/30/2019 for patients receiving both opioids and benzodiazepines in combination. 118 opioid patients were identified who were on ≥ 300 MME. Of these 44 patients were identified who were on both $\geq$ 300 MME and were also on benzodiazepines during the same time period.

		Dr. Gennrich then presented more detailed information on the 44 patients. including the number of overlapping days of benzodiazepines and the number of those with different prescribers for the opioids and benzodiazepines. She then shared 4 specific examples of patients and their utilization patterns. Idaho Medicaid expects that opioid prescribers, especially for patients on ≥ 300 MME, to be checking PMP routinely. Idaho Medicaid will continue to work with prescribers to slowly and safely taper patients down on both opioids and benzos. Typical prior authorization approvals are for 1-6 months depending on taper schedule. The DUR Board recommended that a single page taper plan that is signed by both the prescriber and the patient be submitted to Idaho Medicaid as part of the the PA Process.
• P&T Recommendations on Benzodiazepines	Tami Eide, Pharm.D.	**Slides 88 – 92** Dr. Eide presented the Idaho Medicaid P&T Committee recommendations on the appropriate prescribing of benzodiazepines. Overall Recommendations. • Interventions should be divided into two main areas: initial therapy and continuation of long-term therapy for current utilizers • Initial prescriptions should be for bridging treatment for anxiety disorders while waiting for maintenance treatment with an SSRI or an SNRI to take effect

		• Long-term therapy for anxiety disorders should be limited to small quantities for as needed treatment for acute anxiety episodes. (e.g. 5 tablets monthly)
		
		Dr. Eide detailed P&T Committee recommendations for initial prescriptions for benzodiazepine naïve patients (Stage 1)
		
		• Limit to a 14-day supply with no PA required
		
		• Longer term will require evidence of use of SSRI or SNRI
		
		• Patients would be allowed a 2 week supply every 6 months for as needed treatment
		
		  • Picks up the patients who use occasionally for flight anxiety, etc.
		
		  • Patients who have not filled a prescription for benzodiazepines in the past six months would be essentially considered a new user
		
		And for current long-term patients (Stage 2)
		
		• Prior authorizations will be put in place for these patients while implementing Stage 1.
		
		• The DUR Board was tasked with coming up with a plan for "Deprescribing Benzodiazepines". The DERP report on this subject will be used as a starting place and will be presented at the January DUR Board meeting.
		
		• Recommendations should include deadlines for completions of tapers
		
		Dr. Eide shared the communication plan to providers:

		• Prescriber communication prior to implementing these actions • at least two notices to inform prescribers on actions that will be implemented • The guidance should include communication regarding the use of alternatives such as hydroxyzine and use of CBT for panic disorders
➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	**Slide 93** The following were brought up as potential topics: Expansion numbers, naloxone utilization (Pharmacist Prescribing), Immune Globulins, opioids-gabapentin, esketamine (outcomes/utilization), Sublocade, foster kids/psychotropics, SUPPORT ACT (psychotropic/opioids), butalbital outcomes (change to other medications, decreased headaches)
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	**Slides 95** Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	**Slide 96** Dr. Eide reported that expansion volumes have significantly increased the workloads of the call center and that PA processing is significantly delayed with turn-around time over the usual 24 hours by several days.

➢ **Deprescribing Benzodiazepines: Clinical Evidence and Management Strategies**	Moira K. Ray, MD, MPH	**Slides 97 – 144** Dr. Ray from the Oregon Health & Science University presented the DERP review on clinical evidence and management strategies for deprescribing benzodiazepines. Dr. Ray provided background information on the benzodiazepine class including market introduction, mechanism of action and indications which include short-term use in anxiety, insomnia, post-traumatic stress disorder, seizures, and alcohol withdrawal. She noted that long-term use is associated with a variety of significant harms including falls, fractures, motor vehicle accidents, dementia, and death. The risks associated with these harms include age, co-prescribing with opioids and concurrent use with other central nervous system depressants. Most significantly in 2016, the FDA issued a block box warning for opioid and benzodiazepine coprescribing, which has shown to lead to opioid overdose deaths involving benzodiazepines. She then presented the stepwise process involved in deprescribing medications. She noted that deprescribing is an intentional process of dose reduction or cessation of a medication and is usually initiated in circumstances when harms exceed benefits. She noted that benzodiazepine withdrawal syndrome complicates the deprescribing efforts for this class of medications and while there is no standard taper across guidelines, typically it is a 5-25% reduction weekly. Management strategies covered by Dr. Ray included: • Educational o Patient Targeted o Provider Targeted

		• Pharmaceutical
		  ○ Melatonin
		  ○ Pregabalin
		  ○ Gabapentin
		• Noneducational, Nonpharmaceutical
		  ○ Cognitive behavioral therapy (CBT)
		  ○ Electroacupuncture
		
		She also discussed various agency management strategy approaches which included academic detailing and medication therapy management.
		
		In summary:
		
		• Clinical evidence shows direct-to-patient brochures demonstrate consistent, significant BZD use reductions when delivered by pharmacists in outpatient settings
		• Provider education demonstrates sustained reductions in chronic BZD use
		• CBT improved rates of discontinuation compared to tapering instruction alone
		• Pharmaceutical interventions and electro-acupuncture show no difference in BZD discontinuation
		• Pregabalin may reduce risk of withdrawal symptoms and reduce anxiety symptoms
		• Management strategies show MTM offers an opportunity to engage pharmacies in deprescribing and aligns with evidence for pharmacist-delivered educational interventions for patients.
		
		Additionally, Dr. Ray discussed patient and provider barriers to deprescribing medications.

		The DUR Board recommended that the program proceed with provider education in the form of a patient education handout, and to investigate the potential for an MTM Pilot.
➢ **Adjourn, 12:00pm**	Christine Hahn, M.D.	

Next Meeting: April 16, 2020