Idaho DUR Board Meeting Minutes

Date: October 15, 2020 **Time:** 9am-12:00pm

Location: Idaho Medicaid, WebEx Meeting

Moderator: Magni Hamso, M.D.

Committee Member Present: Sabrina Allen, Pharm.D., Wayne Baures, RPh, Perry Brown, M.D., Chris Owens, Pharm.D., Chris Partridge, M.D., Dawn Berheim, Pharm.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**	Magni Hamso, M.D.	Dr. Magni Hamso, Chairman, called the meeting to order.  DUR_10_15_2020_Final.pdf
➢ **Review of Minutes from April 16, 2020**	Magni Hamso, M.D.	Minutes were approved as written.
➢ **Treatment of Spinal Muscular Atrophy (SMA)**	Jane Gennrich, Pharm.D.	**Slides 2 – 20** Dr. Gennrich gave an overview of Spinal Muscular Atrophy (SMA) including its etiology and the four classification types and their severity, symptoms and ages that typically correlate with each. She reviewed the three commercially available drugs including their

		indications, mechanisms of action, dosing regimen and cost of therapy. She reported that there are currently 15 Idaho Medicaid patients approved for nusinersin, four with Type 1, eight with Type 2, and three with Type 3. Ten members are receiving treatment in Salt Lake City, three in Boise, and two in Seattle. Dr. Gennrich provided the Board with the ages when these members started therapy. From October 1, 2019 through September 30, 2020, Idaho Medicaid has paid out $3,520,171 for 28 doses of nusinersin. Additional cost was offset by other insurance. One request for onasemnogen abeparvovic-xioi has been approved and there have been no requests yet for risdiplam. Dr. Gennrich shared that there are currently three drugs in Phase 2 trials, two drugs in Phase 1 trials and many others in pre-clinical trials. Spinal muscular atrophy (SMA) was added to the federal Recommended Uniform Screening Panel (RUSP) for newborn screening in 2018 and 32 states currently screen as part of the newborn screening process. Idaho is not one of those states currently. Dr. Hamso asked Dr. Eide to discuss value based purchasing as it relates to the high dollar priced drugs such as those used in this disease state. Dr. Eide provided insight and explained how it relates to medications specifically and how it can differ from what is seen in other medical areas, as outcomes are associated with payment for the drug and agreements with the drug manufacturers rather than reimbursement to Medicaid providers.
➢ **Annual DUR Report Highlights**	Tami Eide, Pharm.D.	**Slides 21 – 42** Dr. Eide began by giving the historical background on the existence of state DUR programs. She then highlighted the 12 sections and eight

		attachments that were submitted to complete the Annual Report to CMS. One question noted as significant this year was: Do you receive and review follow-up on periodic reports providing individual pharmacy provider DUR alert 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 that should be considered in future DUR Board activities. One additional highlight called out was that Idaho was able to answer "yes" to "Does the state Medicaid agency or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?" 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. Information on generic drug utilization and expenditures; cost savings/cost avoidance; fraud, waste and abuse detection; pain management controls in place; opioid prescribing and utilization improvement activities and provider and beneficiary fraud and abuse were reviewed. She highlighted retrospective educational outreach activities as well as DUR Board activities, innovative practices, and executive summary highlights.
➢ **Naltrexone Extended Release Microspheres Injection**	Dawn Berheim, Pharm.D. and Magni Hamso, M.D.	**Slides 43 – 61** Dr. Berheim reviewed specific information on naltrexone's mechanism of action. Dr. Hamso reviewed naltrexone's evidence in both alcohol use disorder and opioid use disorder with a deeper dive into numerous studies on the use in opioid use disorder. Dr. Hamso

		shared with the DUR Board a warning letter to Alkermes from the FDA for misbranding their drug by omitting warnings about the most serious risks associated with the drug from promotional materials, including vulnerability to opioid overdose, a potentially fatal risk. Dr. Berheim shared the current Idaho Medicaid Coverage criteria including FDA approved indications and additional requirements. She shared Idaho Medicaid's utilization of naltrexone from March-May 2020 by dosage form and indication, as well as participant country of residence and number of patients by prescriber. In conclusion: • Data for extended release naltrexone in OUD is very limited and potentially harmful. It does not appear to protect against overdose like opioid-agonist therapy and has not been proven to decrease deaths. • Extended release naltrexone represents 11% of overall naltrexone use • Extended release naltrexone use for OUD is low (12 vs. 1454 on buprenorphine) • No patterns of use of non-preferred agent by region or prescriber • Still have a lot of work to do to increase access to MAT A recommendation was made to look further into oral naltrexone utilization.

➢ **Implementation of a Prescriber Attestation Process for High Dose Opioid Use**	Dawn Berheim, Pharm.D.	**Slides 62 – 68** Dr. Berheim provided background for this project. The program's strategic objectives to improve safety of opioid prescribing are to reduce high dose opioid prescribing where possible, increase access to naloxone, incorporate attestation of provider on key clinical best practices, and streamline processes. She shared with the DUR Board how 5 historical Prior Authorization forms were combined into 1 form along with the addition of a combined opioid (MME) calculation (all concurrent opioids being received) and 12 prescriber attestation questions. She noted the challenges of completing the new form as an adjustment for prescribers as well as third party services defaulting to historic or universal PA forms. Next steps involve hardwiring use of the new process, refining the form as needed and monitoring the form's impact including MME>90 trends, naloxone prescribing trends and overdose events. The form also lays the foundation for identifying future opportunities.
➢ **Naloxone Prescribing Trends**	Dawn Berheim, Pharm.D.	**Slides 69 – 77** Dr. Berheim shared with the DUR Board that the program goal is to improve availability of naloxone for patients at high risk of overdose from opioid use associated with chronic pain or addiction. Dr. Berheim pointed out to the board in reviewing the utilization over the past few years that the raw number of claims for naloxone is increasing, but so are the number of program participants. Utilization review shows that at-risk patients are not routinely receiving

		naloxone medication nor are patients on buprenorphine for Opioid Use Disorder receiving naloxone for rescue. She reviewed three pharmacy unit current or possible future interventions. The first sent targeted letters to pharmacies asking for naloxone prescribing for identified high risk patients. 34 letters were sent out and results showed 13 (37%) participants subsequently had a filled naloxone prescription. Although this was a decent response to the intervention, it was resource intensive and reached few patients. The second intervention is the current addition of a statement on the new PA Form under the attestation section for the prescriber to note if naloxone has been filled within the last 12 months. The third intervention was an investigation into the possibility of a notification to the pharmacist at the time of prescription filling when a combined MME > 90 and no history of naloxone in last 12 months are present. Testing of this intervention failed as system functionality is unable to currently support this intervention. Next steps involve monitoring effectiveness of the naloxone prospective intervention as it applies to high dose opioid users and non-preferred agents, addition of a naloxone prescribing prompt to the stand-alone methadone prior authorization form and identifying buprenorphine co-prescribing intervention opportunities.
➢ **Benzodiazepine Limitation to 14 Days Supply per Six Months**	Mark England, Pharm.D.	**Slides 78 – 84** Dr. England shared a report that was run to identify Idaho Medicaid members who had 15 days supply or greater of an oral benzodiazepine between the dates of 8/16/2020 and 9/30/2020. A total of 4,891 unique members with 5,103 claims were identified. Of

		those members, 71% were female, 29% male and the majority were between the ages of 30-59. The top four drugs utilized accounting together for 97% of the claims were clonazepam, alprazolam, lorazepam, and diazepam. Dr. England reported that a new prior authorization rule was implemented in the FirstRx Claims Adjudication System on August 17, 2020. The rule allows a maximum duration limit of 14 days of supply during a rolling 180-day period for any combination of oral benzodiazepine(s). Any participant who has a claim that falls out of this edit in the claims adjudication system will have that claim deny at point of sale and it will require a prior authorization approval from the Idaho Medicaid Clinical Call Center to fill the medication. Magellan Rx created 5,103 temporary prior authorizations for the identified 4,891 unique members currently hitting this edit. These PA's have a termination date of 9/30/2021. A copy of the notification letter that went out to prescribers and pharmacies was shared with the DUR Board.
➢ **Benzodiazepine Rescue Agents**	Chris Johnson, Pharm.D.	**Slides 85 – 92** Dr. Johnson shared with the DUR Board the three current agents approved for acute treatment of seizures which includes diazepam rectal gel R, midazolam nasal spray (NS), and diazepam nasal spray (NS). Data for this review was collected from 3Q2020 looking at the number of unique clients for each agent, number of claims of each agent, and prescribed age groups. # of clients: diazepam R 80 (51%), midazolam NS 54 (35%), diazepam NS 22 (14%)

		# of claims/# of units: diazepam R 114/162, midazolam NS 95/238, diazepam NS 25/120 Age groups: majority of diazepam R 0-10 y/o, majority of midazolam NS 11-20 y/o, and majority of midazolam NS 11-20 y/o In conclusion: 51% of total clients are prescribed diazepam rectal gel with most of diazepam rectal gel utilization in the younger population. Midazolam NS has greater utilization in the adolescent and mid-age clients and diazepam NS has limited utilization across all age populations. Future review will look for the presence or absence of seizure disorder and adequacy of maintenance medications.
➢ **Clonazepam**	Chris Johnson, Pharm.D.	**Slides 93 – 100** Dr. Johnson shared with the DUR Board a follow up review of from the January 2020 DUR Meeting where clonazepam utilization was reviewed for seizure disorders. Clonazepam utilization with ICD-10 codes related to seizures or epilepsy showed 278 unique clients (22% of total unique clients), 729 claims (24% of total claims) and 65% female and 35% male. This current review looked at indications for clonazepam not related to seizure disorders. Claims from August 1, 2019 – October 31, 2019 were reviewed. ICD-10 Codes for all patients with clonazepam claims were pulled and excluded were G40.XX Epilepsy and recurrent seizures and G80.XX Cerebral palsy and other paralytic syndromes. Results: Total of 52,070 ICD-10 codes reported.

		6,608 unique ICD-10 codes reviewed. Reviewed the most common ICD-10 codes that may be related to clonazepam use other than seizures. Total unique clients= 1,086 Female=799 Male=287 Mean age=40 (2 - 80 y/o) Dr. Johnson shared a chart showing the breakdown of percent of ICD-10 by category and went into detail what each group included. Major groupings included mental disorders (mood disorders and anxiety) and diseases of the musculoskeletal system. In conclusion: ICD-10 reports to match with drug treatment is complicated and accuracy of coding is difficult to validate.
➢ **Gabapentin Utilization**	Chris Johnson, Pharm.D.	**Slides 101 – 111** Dr. Johnson reported on gabapentin utilization in the Idaho Medicaid population. Gabapentin is currently FDA approved for seizure disorder, restless leg syndrome, and post herpetic neuralgia. He reported that gabapentin is one of the most widely used off-label agents and utilization has increased 64% from 2012 to 2016. Off-label uses include migraine prophylaxis, nystagmus, spasticity due to Multiple Sclerosis, hot flashes, uremic pruritis in hemodialysis, brachioradial pruritis, orthostatic tremor, essential tremor,

		fibromyalgia, dysautonomia, short-lasting unilateral neuralgiform headache, diabetic neuropathy, alcohol dependence, and postoperative pain. The Idaho Medicaid P&T Committee requested that the DUR Board review gabapentin claims in Idaho Medicaid population, review possible diagnosis ICD-10 codes related to gabapentin utilization, and Identify any areas of potential misuse or patient risk. Gabapentin utilization data was collected for calendar year 3rd quarter 2020 claims. Data was also collected for all ICD-10 codes of clients with gabapentin claims. Dr. Johnson shared that there were 7,427 total clients with 4,979 for females and 2,448 for males. He then shared the breakdown by strength by number of claims and mean quantity per day of the 17,977 total claims reviewed. Looking at the total 262,166 ICD-10 codes reported, Dr. Johnson found 9,270 unique ICD-10 codes and reviewed and shared the ICD-10 category of codes with the Board. It was concluded that ICD-10 reporting to match with drug treatment is complicated. The accuracy of coding is difficult to validate, and generalizations from data to determine indications for gabapentin use can be stated that a high use of gabapentin is for off label treatments with spondylopathies, joint pain, mood, anxiety disorders, polyneuropathies and other disorders of the peripheral nervous system being the most common seen in the coding reviewed. Dr. Johnson then shared a systematic review on gabapentin misuse in the general population.
➢ **Hepatitis C Update**	Chris Johnson, Pharm.D. and Magni Hamso, M.D.	**Slides 112 – 124** Dr. Johnson discussed the HCV Guidelines introduced on 8/11/2014 by the American Association for the Study of Liver Diseases (AASLD)

		and Infectious Diseases Society of America (IDSA). He reviewed the history of the three prior authorization criteria changes by Idaho Medicaid from 2014 to 2017 which mainly increased availability by opening up to all levels of HCV fibrosis staging. He also reported on the increase in utilization following the January 1, 2020 Medicaid Expansion. Dr. Johnson shared data for calendar year 2014 though 3Q2020 breaking it down with gender, genotypes, fibrosis-staging, specific HCV agents utilized by # of claims, as well as the drug costs before rebate. Dr. Hamso shared with the DUR Board information around the HCV Medicaid Affinity Group. Idaho is one of nine states participating in the Hepatitis-C Medicaid Affinity Group. The goal is to increase the number and percentage of Medicaid beneficiaries diagnosed with hepatitis C virus who are successfully treated and cured. The Affinity Group addresses this need by bringing states together to support developing and implementing innovative strategies for scaling up HCV screening, treatment, and cure. Dr. Hamso shared some Idaho specific numbers as it related to data collected and the results of Idaho HCV Medicaid Affinity Group Initiatives percentages. More work is need in the following areas: Increase HCV screening, confirmation of HCV diagnosis, increase referrals to HCV treatment, and implementation of an HCV Project ECHO (Extension for Community Healthcare Outcomes) program for Idaho providers.
➢ **Medicaid Expansion Pharmacy Update**	Tami Eide, Pharm.D.	**Slides 125 – 136** Dr. Eide shared with the DUR Board a Pharmacy update on the Medicaid Expansion population. Membership and Utilizers continue to rise and as of the end of September there were 89,742 expansion

		members (participants) and 32,160 drug benefit utilizers. The total drug spend for these participants was at $11,860,487 for September 2020. She then broke down the drug spend in more detail by traditional and specialty drugs and shared the Top 20 Drug Expenditures over 3Q2020 for the Medicaid Expansion Population. Dr. Eide presented an overall comparison to prior quarters which included all members looking at both paid claims as well as expenditures. In terms of Pharmacy Workload, numbers are higher than prior to Medicaid Expansion, but have trended down a little from 1Q2020 and have started to plateau over the past two quarters. Looking at details for January to June 2020 compared to the same period in 2019: • Expenditures – up 60 % • Paid Claims – up 54 % • Utilizers – up 51 % • Cost/Claim – up 4 % • Cost/Utilizer – up 6 %
➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	**Slide 137** Potential topics suggested: Disease Modifiers/BLA's, AUD/OUD Affinity Group data, follow up with 4Q2020 benzodiazepine utilization numbers, and children on clonazepam.
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	**Slides 138 - 140**

		Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **Medicaid Update**	Tami Eide, Pharm.D. and Magni Hamso, M.D.	**Slide 141** Dr. Eide shared with the DUR Board work with movement towards Value Based Care and where pharmacy fits in. Dr. Hamso shared with the DUR Board SUD/Behavioral Health Initiatives and information on Telehealth.
➢ **Adjourn, 12:00 pm**	Magni Hamso, M.D.	

Next Meeting: January 21, 2021