Alaska Medicaid DUR Committee Meeting Minutes

Friday, November 17, 2017

Frontier Building, 3601 C Street; Room 880

1:00pm

November 17th 2017 Drug Utilization Review Committee

Members Present	Non Members Present
Dr. Bob Carlson, MD	John McCall RPh Magellan
Dr. Denise Eavey. PharmD	
Dr Jenna Hiestand. MD	
Dr. Erin Narus. PharmD (DHSS)	
Dr. Barb Piromalli, DO	
Dr. Ryan Ruggles, PharmD	

Introduction

- Erin Narus asked if there were any members from the public present who were health care providers who would like to comment. There was one pharmacist who presented himself.
- Erin announced that the September 2017 meeting minutes will be circulated to members for review via e-mail.

Step Edit For Statins

- Erin Narus recommended removal of the step edits for statins. This was a recommendation received from Magellan. If a generic is available generic would be preferred. She asked if the committee members would support the evidence to remove the step edit. Dr. Bob Carlson commented that if it is was using resources without benefit then it would be appropriate to remove the step edit. Dr. Bob Carlson motioned to remove the step edit for statin drugs. The motion was seconded by Ryan Ruggles. The motion passed unanimously.

Hemophilia

- Erin Narus presented information related to Hemophilia. Hemophilia has been consistently in the top 5 drug classes related to drug costs. Erin reiterated the state's responsibility to assure appropriate utilization of resources related to Hemophilia.
- Erin Narus noted that historically steady state levels have been on demand, for factor VIII, IX and for Vonwillebrand. New research has promoted prophylaxis dosing to prevent joint damage, brain bleeds etc. Given that it is a genetic disorder, hemophilia is a chronic disease, with infusions on frequent bases, good patient care requires family and social support. Prophylaxis dosing is important. On demand use needs to be accessible. Need a broad standard of care. Erin presented the current products that are available. Hemophilia agents are covered products. They are not a reviewed class on the Preferred Drug List. The products currently need prior authorization based on cost over $7,500.
- The current form used to monitor usage clotting factors by the state as part of the prior authorization process is labor intensive. It is an accounting process, to see what is left in the home. It is a reactive process rather than proactive. The cost puts pharmacies in a hard spot. As they supply and wait for approval. After discussion with pharmacy providers Erin would rather move towards integrative care.
- The recommended program for clotting factor patients, is primarily for genetically based reasons for clotting disorder, versus acquired but the state would follow both. Currently, the prescriber is not required be part of the Hemophilia Center, eventually Erin would want to move that direction. There is a hemophilia treatment center here in Anchorage, there are 3 down in Washington.
- Providers must agree to the standards of treatment care outlined. There must be a treatment plan document in place. Authorization would be approved in consideration of the treatment plan. Treatment plans in advance enable approval for longer approval times. Pharmacies and providers would help to identify areas of support related to plans. Erin stated we would rather pharmacies spend time reviewing patient care rather than counting vials.
- Authorization is based on a set treatment regimen both a prophylactic and an as needed for bleed. Infusion logs would still be provided to pharmacies to monitor but approval would not be based on logs. Initial coverage would be 3 months, some patients could receive 6 or 12 months once stable. Authorization would be assigned to a specific patient, physician and pharmacy provider. It would be a treatment team mentality. The process and program would promote a single pharmacy provider. There will not be specific quantity limits other than a 30day supply.
- For a 3 month prior authorization treatment plan, the state would allow a 5% plus or minus tolerance as payer. Variances would be allowed if there are product access issues. The current form does not require diagnosis. The new form will. An annual screen for inhibitors will be part of program. Prescribers who intend to prescribe clotting factor to Medicaid patients will be required to be affiliated with the regional hemophilia treatment center near the patient's residence.

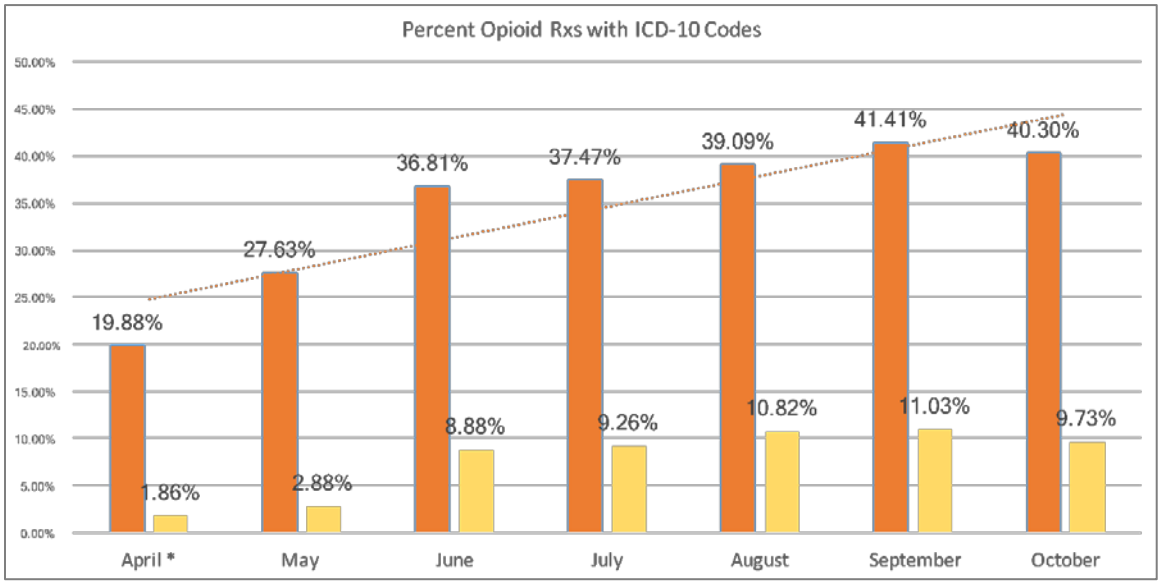
- The prescribers would retain ultimate treatment authority. The prescriber is the team lead and oversee all activities. Prescribers would also be informed of the Alaska Medicaid Coordinated Care Initiative. This program is useful in other areas with Alaska Medicaid. Pharmacy Providers would be required to notify the department at least annually in writing before July first of each year intent to dispense clotting factors to Alaska Medicaid patients. Dispensing pharmacy would provide contact information. These pharmacies would have someone on call 24 hours a day. Eventually Erin would like to see the pharmacies move towards connection with nursing services.
- Home assessment needs to be part of the program. Inventory of items, Infusion logs etc. being aware of unique delivery challenges. The patient can choose the pharmacy within the program. Patient and care giver would initiate initial fill. The pharmacy needs to be tracking for compliance. Pharmacies should aid in contacting patient to prevent missed prophylactic doses. The specifics will be posted. Goal is integration of therapies.
- Supply requirements would be as follows:
  - The pharmacy needs to acquire the factor that the MD prescribes or refer the patient to another pharmacy. Enough of a supply needs to be available for emergency bleeds, approximately 5 doses. Ensure that recall process is in place. Patient counseling is required as a supplier.
- The prescriber is responsible for product selection. The pharmacy should not be pushing the prescriber towards certain products based on financial advantage rather than clinical judgement. Public Comment from a pharmacist- Dispensing on an emergency basis is an issue, pharmacies uses what they have in stock. Erin stated that in an emergency situation to supply what the pharmacy has in stock is appropriate. The state may audit to avoid this issue and in keeping with standards of practice.
- Provider training and education.
- The state would want to make sure that they have appropriate education and training. Pharmacists involved in dispensing would be required to have 2 CE hours related to hemophilia therapy annually. Nurses would be required to have 4 CE hours annually.
- The DUR committee gave consent for Erin to develop these guidelines further. Erin acknowledged Tracy Stephens in helping research standards of care.

Opioid Initiative – ICD Codes on Opioids

- Erin Narus gave a review of the state's current policy related to ICD 10 codes for opioid prescriptions. Since March 2017 ICD diagnosis codes have been required for opioid prescriptions. The physician provides the ICD code on the prescription. The pharmacist submits the ICD10 code at point of sale. This is a soft recommendation to ensure that patients receive their prescriptions.
- Pharmacists can use submission verification code if the ICD10 is not available to allow the patient to get their medication. The state has been monitoring the program since April. Erin commented that of all of the things this committee the has done this may have the greatest

potential for benefit. Connecting diagnosis with the prescription provides more data and information.

- John McCall explained the data for pharmacy and prescriber compliance. John McCall presented and explained the graphs associated with ICD 10 compliance. The data was pulled for all opioid prescriptions. If pharmacy gets prescription and cannot get ICD10 from the prescription than they can call the prescriber. If still unavailable the pharmacy can use the ICD10 override. Those physicians that have electronic prescribing the potential for improving compliance is great. The percentages presented each month were as follows:



- April has 11 days, May was the first full month and showed 28% percent compliance. Compliance rose as months progressed. Erin explained some prescriber groups used electronic prescribing and they had 100%. Others without had 2% with no electronic prescribing. The state will reach out to pharmacies and prescribers. Trending was close to 40% by July based on the soft edit. By August 39% was reached. In September 40% was crested. Prescriptions that were electronic remained steady at 25%. Erin noted we can still make a larger dent. John McCall has worked with the Providence Epic developers. Epic has an easy drop down menu for selecting a diagnosis for each script. As we are beginning to level off we see where we can make a difference with education.
- Erin stated that a lesson learned is that there are technology limitations without e-prescribing. To be compliant sometimes those are written by hand on or through feedback from pharmacy.
- Dentists do not use ICD10 codes. There is override code allowed for them but can still capture dental code without since system will look to see if it is a valid code. This is a soft edit so we can focus efforts. The codes we have seen so far related to ICD codes helps us know where to start. The results are pretty telling. Of the 40% where we have ICD codes we know that Medicaid is paying for the 2 biggest spikes is lower back pain followed by other chronic pain. This is not terribly descriptive. Oregon just recently stopped allowing opioids for lower back pain. This gives areas of focus. We will try to find ways to move to opportunities where opioids

are less relied upon. This was pretty telling and is a good starting point for education. The other 60% is a concern however it will be interesting to see a complete data set. All based off initial data. Not necessarily reflective of what is really happening out there. This was 2017 September data and will be used for modeling going forward and help craft our program. There was no ICD prior to the start of monitoring.

- Erin displayed a scatter plot diagram displaying quantity dispensed over day's supply. Erin asked the question. Are initiatives we are doing going to make a difference? Hopefully this will come down as judicious prescribing occurs. Current opioid naïve guidelines use term as days' supply as defined by MME only. Left side of graph will be seen over time to start seeing newer data collapse and shrink with flatter line across the board.
- Dr. Hiestand questioned if Erin will have PDMP data? She asked if letters would be sent out, The next step would be to identify those clinics/pharmacies doing well and offer encouragement and education. Erin described the Morphine Milligram Equivalent slide. Overall the graph is based on MME. Erin described the slide pointing out a great portion or the claims are under the 200 mark. As you get into the monthly prescriptions the MME numbers rise and will be opioid dependent over time.
- Erin stated that Magellan did a fabulous job with the overrides and did close to 20 to 30 point of sale tests. Because the ICD 10s will be coming we can start using technology for the overrides to occur for certain pain diagnoses. Also with this we will be able to put together education on these overrides.
- Partial fills do work in our system. When pharmacies partial fill they will get the full dispensing fee up front. The patient can come back and get remaining portion of prescription filled. Due to less large fills this keeps excess product out into the communities. The CARA act allows partial fills for schedule 2 narcotics for up to 30 days if it is requested by the patient. Erin stated the point of sale system set up in Alaska has a dispensing fee for the initial fill and no dispensing fee on remaining partials. Erin stated that this was a tool to look into prescribing practice of opioids. Patients who sit above the MME will be presented to the prescriber. More refining will occur.
- Dr. Hiestand asked about the presence of fraudulent prescriptions. Ryan Ruggle brought up that electronic prescribing and the PDMP have reduced many fraudulent scripts. Erin asked the committee how do we most effectively communicate to pharmacies and pharmacists to make sure they are knowledgeable of rules and overrides for oncology and hospice. Ryan Ruggles noted that one problem was no access to the internet at the pharmacy. Pharmacists cannot lookup current criteria.
- Erin expressed the need to break down information in bite size pieces. We want to make sure what we send out is effective and not just one way. Inbound feedback necessary. Ryan Ruggles stated that dissemination by fax or scan has been used. Erin stated that we have periodic reports, pharmacy association meetings.
- Ryan Ruggles stated one thing that has changed is massive turnover in pharmacies that has lead to a lack of passed on understanding. Denise Eavey stated that long term pharmacy

technicians can do many things for you Erin stated that automation is best option and her primary thought.

- The work orders Erin writes for return message outbound to pharmacies. Do pharmacies see this? Denise Eavey stated the message does come through. Ryan Ruggles stated the message gets lost in the information. They stop reading once they see something is required. Erin stated we have more space now with 200 character. It gives ample characters to explain. Do the pharmacists see the whole screen? Ryan Ruggles commented a screen shot on a test patient could be done.
- Erin stated this information is usable. Ideas are needed. How do people learn?, How do they retain knowledge. She expressed concern with 60% scripts not coming in with ICD10 code.
- Erin Narus stated taking prescribers taxonomy information is another option to show overall purpose, prevent diversion, and encourage appropriate opioid use. Oncology and hospice should get what they need. Diagnosis is most succinct and straight forward. The plan must meet the needs of the pharmacies in terms of education. Erin asked the committee that if they had other ideas to let her know. She would like to see the process more automated. Erin is updating protocols at the call center. The call center will be asking about oncology or hospice early rather than later in order to speed up approval.

BREAK

- Erin displayed the medication assisted therapy for substance abuse slide. Currently single agent buprenorphine products are limited to females. Since the system cannot interpret a pregnant female. Male patients on buprenorphine single agents through outreach were moved over to combination product. Afterwards a hard edit was put into place. From the feedback Erin received for some patients a combination product is not an option.
- Erin is moving towards a Gold Star Program based off of the Virginia model. These Gold Star prescribers would be meeting all best practices with supportive care, etc. These prescribers would no longer require prior authorization.
- Currently the Prior Authorization Criteria for approval is as follows: Patients new to buprenorphine within previous 60 days will not require PA – goal to get patient on day 1, demonstration of connection to supportive resources allowed. Prior authorization Criteria Continuation of therapy has met, patients not receiving other narcotics, benzos, tranquilizers or consuming alcohol.
- Dr. Hiestand asked if there were potential sanctions if a prescriber prescribes buprenorphine and Oxycontin. She has observed a fairly large number of prescribers prescribing benzodiazepines, stimulants, CNS depressants, and zolpidem to the same patient at the same time.
- Erin stated that according to the FDAs statement the end of September 2017 that caution should be used when benzodiazepines and CNS depressants are combined, but it can be done. Others in the group say it's probably not a good idea. Dr. Hiestand stated that current guidelines do not agree with the FDAs statement as only a caution.

- Erin asked the committee if we should forego the MAT because of the presence of another CNS drug. Dr. Hiestand stated there was a fairly large outcry that the FDAs statement was irresponsible. Medications should be tapered since patient has been on long term and it is dangerous if not done. Dr. Hiestand further stated that the other opioids should be tapered off first. Vivitrol is an option. Chronic benzodiazepines are not supported by literature or guidelines.
- Erin asked the committee how to go about operationalizing the policy. Should a transition period be provided to get patients off benzodiazepines into more appropriate therapy? Dr. Hiestand said that she will not accept a patient if they are on a benzodiazepine in her practice. Taper them off first than start suboxone. With current criteria patients cannot be taking other narcotics.
- Patient and prescriber must have a defined treatment plan, the projected dose not impose an absolute stop date. We would want to see that there is a timeline. Erin stated that Alaska Medicaid allows no more than 24 mg as a dose for buprenorphine. There are some people who are maintained at 24 mg but 24 mg does not mean that it is the final maintenance. There are a number of people on 18 -24 mg.
- Dr. Hiestand suggested ACE guidelines as the reference standard, 4mg then 8mg, final dose 12-16mg as maximum. Dr. Hiestand stated that 12 mg is the most common maintenance dose in her practice. Doses beyond the range flood the receptors and efficacy is lost. 24 mg has diversion potential. Dr. Hiestand pointed towards utilization presented in P&T and noted a large amount of Subutex and expressed concern that it could be abused. Dr. Hiestand pointed out the large amount of Subutex claims over a year in the utilization report provided to the P&T. There were more claims for Subutex than Suboxone Dr. Hiestand stated. Some states restrict to females pregnant or lactating. Our system stops the use of buprenorphine only for males.
- There was discussion about adverse reactions and what would be considered an adverse reaction to the naloxone. The committee agreed adverse reactions would be exceedingly rare. Erin asked the committee if they wanted a zero tolerance policy. Dr. Hiestand asked what do other states do? Erin Narus stated that Washington state is a no. Ryan Ruggles suggested that the state write the criteria and present for discussion. He stated it should be looser than anaphylaxis only. Dr. Heistand disagreed due to abuse potential. Dr. Heistand suggested that there are standards and guidelines out there that we could review.

Gold Star Provider Guidelines:

- Erin Narus presented criteria for Prescribers to be Gold Star. A gold star provider would not have to seek prior authorization for approved MAT products. The Prescriber must demonstrate quality standards of practice as described below.
- Prescriber would have a coordinated care plan with another practitioner involving counseling and therapy. Prescribers are responsible to routinely screen for anxiety and mental health challenges and provide supportive access to care. If the patient has chronic pain the provider would develop a patient centric treatment plan that optimizes the use of non-opioid pain

therapies. Patients are encouraged to enroll into the AMCCI program, the Alaska Medicaid Coordinated Care initiative.

- Prescriber are responsible to seek prior authorization for continuing therapy in a timely manner to avoid the patient not having access in sufficient time to medically necessary treatment. If a patient requires prior authorization the prescriber is responsible for making sure it is done on time.
- Prescribers are responsible for maintaining an up to date treatment plan and reviewing every 6 months with the patient. Trial tapers to lower maintenance doses should be considered in patients who have been stabilized and the patient demonstrates readiness.
- Dr. Hiestand suggested other actions like checking the PDMP, drug screens and film wrapper counts. Dr. Hiestand offered to send over policies to assist. Dr. Hiestand also suggested 8 urine drug screens a year including random call backs, film wrapper counts every visit, a lock box each visit so that they have to bring it back and checking the PDMP every visit. Patients also sign releases that they have a medical relationship and their pharmacy and they can only go to one pharmacy.
- Erin stated that she will get a draft to committee members. It could be approved by e-mail.
- Dr. Hiestand is going to the American Academy of Addiction Psychiatry. She will look for more information. The committee would be okay with voting remotely.

Ryan moved to adjourn.

Dr. Hiestand seconded.