Iowa Medicaid Drug Utilization Review Commission
Meeting Minutes December 4, 2013

Attendees:

Commission Members
Mark Graber, M.D., FACEP; Laurie Pestel, Pharm.D.; Jason Wilbur, M.D.; Gregory Barclay, M.D.; Kellen Ludvigson, Pharm.D.; Larry Ambroson, R.Ph.; Brett Faine, Pharm.D.; Brian Couse, M.D.; and Susan Parker, Pharm.D.

Staff
Pam Smith, R.Ph.

Guests
Chuck Wadle, D.O., Magellan; Jason Kessler, M.D., IME; Erin Halverson, R.Ph., IME; Megan Smith, Pharm.D., IME; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Graber called the meeting to order at 9:31 a.m. at the Learning Resource Center in West Des Moines. The minutes from the October 2, 2013 meeting were reviewed. Dr. Couse motioned to accept them, and Dr. Wilbur seconded. The vote was unanimous.

IME Updates

There has been a steady increase in enrollment of both providers and members for the health homes for people with chronic diseases initiative. However, growth of the program had not been as anticipated, so Medical Services has been conducting on-site visits to identify what practices need and how IME can support them. A health home version two will be rolling out in the spring which hopefully will address some of the barriers that may have slowed the progression of the provider and member participation. The second phase of the integrated health homes for members with serious and persistent mental illness and serious emotional disorders will begin in April 2014. The IME successfully applied for a grant to assist in implementing the core adult quality measures, and is working on two quality improvement projects associated with that, the first targeting a reduction in admissions for short-term complications of diabetes, and the second aiming to reduce emergency department use for patients with asthma. A separate quality improvement project aims to improve birth outcomes through decreases in tobacco use in pregnant mothers. IME has applied for a CMS innovation model design grant to develop a multi-payer ACO model based on existing private payer and Medicare efforts already forming in the state. IME is working to get the Iowa Health and Wellness Initiative implemented. Erin Halverson also provided an explanation of the Pharmacy Provider Portal. Informational Letter 1309 explained the tools available within the new system, and listed the requirements for provider access to it. A POS edit will be implemented requiring a statin medication in a member's claim history prior to payment for *Zetia*.

Prevalence Report Summary

Statistics from September though October 2013 were discussed, including: cost per user ($251.67), number of total prescriptions dispensed (an increase of 4.9% compared to the previous reporting period), average cost per prescription ($58.53), and generic utilization (83.3%). The total paid amount increased by 3.4% from the previous reporting period. There were 153,444 unique users, which is 9.1% more than the total for July and August. Lists of the top 20 therapeutic classes were provided. Atypical Antipsychotics were the most expensive (though the percentage of the budget is decreasing due to release of multiple generics), and Stimulants-Amphetamines-Long-Acting came in second. SSRIs had the highest prescription count, and Anticonvulsants came in second. The top 100 drugs were also reviewed. The ten most expensive medications were: *Abilify, Vyvanse*, methylphenidate hcl er, *Focalin XR*, *Advate, Adderall XR, Cymbalta, Lantus, Advair Diskus*, and *Strattera*.

Case Studies

Pam Smith presented 4 case studies. Recommendations by Commissioners from these four examples resulted in annualized total savings of $1,100.72 pre-rebate (state and federal).

Public Comment

Name	Representing	Drug/Topic
Nancy Bell	Pfizer	Lyrica, opiate utilization
Dr. Nick Burnett	Himself (family practitioner)	Prior authorization criteria and process
Rachel Anhorn	Boehringer-Ingelheim	Tradjenta
Rebecca Blair	Herself (ARNP at pain management clinic)	Opiates and non-opiates prior auth criteria
Luciano Kolodny	Merck	Januvia

Injectable Medications Reimbursed through Pharmacy POS

With the expansion of home health care, more medications are being provided in the home. With the increase in home health care services, the Preferred Drug List (PDL) was expanded to allow for administration of injectable medications in the patient's home. A report detailing injectable drugs from the August 2013 paid claims report was reviewed at the October DUR Meeting. Afterward, Pam Smith ran a report to identify how many injectable drugs are for Plan 300 members, and a search was done on medical claims to identify any providers billing for medications that were already paid through pharmacy POS. Pam Smith also looked into how other states are handling this issue. The April claims data did not reflect double billing, and pharmacies were contacted to inquire how members had been receiving their injectable medications. There was one instance where *Zostavax* was picked up by a member, and some were shipped to the members' homes where they were most likely administered by a home health professional. The Commission was unable to offer a solution that would be fair to both providers and members, and ultimately decided to allow IME to establish solutions internally for now, with no formal criteria change or additional restrictions.

Opiate Utilization in Iowa

Between January and March of this year, 13,633 unique members over the age of 18 were found to have more than 30 days of utilization of narcotic and non-narcotic pain

medications. A PowerPoint presentation was provided to the P&T Committee at the August meeting showing state-wide narcotic usage and growth by county. The P&T Committee referred this information to the DUR Commission for further review. Specifically they suggested analysis of outlier narcotic prescribers and review of prior authorization criteria associated with narcotic and non-narcotic medications, such as the medications within the chronic pain syndromes category. After reviewing the information that had been provided, the DUR Commission agreed that the claims data needs to be analyzed. The re-run data will identify outlying prescribers, and break down medications by those that are long-acting, short-acting, or non-opioids. Number of prescriptions and number of tablets will also be evaluated. The Commission also wants to look at utilization data for tricyclics, gabapentin, nortriptyline, *Cymbalta*, *Lyrica*, and NSAIDs, and pull the efficacy stats for *Cymbalta* and *Lyrica*. They were curious if heroin use has increased in other states that have increased opioid restrictions.

Prior Authorization

Sodium Oxybate (Xyrem): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered for patients 16 years of age or older under the following conditions:

1. *A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including PSG, MSLT, and ESS) and previous trial and therapy failure with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline.*
2. *Patient is enrolled in the Xyrem® Success Program.*
3. *A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant.*
4. *Patient has been instructed to not drink alcohol when using Xyrem®.*
5. *Patients with and without a history of substance abuse have been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence.*
6. *Requests for patients with concurrent use a sedative hypnotic, or a semialdehyde dehydrogenase deficiency will not be considered.*
7. *The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at https://pmp.iowa.gove/IAPMPWebCenter/ prior to requesting prior authorization.*

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Dr. Wilbur motioned to accept the criteria, and Brett Faine seconded. All members were in favor.

Anti-Diabetics, Non-Insulin Agents: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for anti-diabetic, non-insulin agents. Payment for

preferred agents will be considered under the following conditions:

1. *A diagnosis of Type 2 Diabetes Mellitus, and*
2. *Patient is 18 years of age or older, and*
3. *The patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated.*

Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor ***and*** *a preferred Incretin Mimetic at maximally tolerated doses, unless evidence is provided that use of these agents would be medically contraindicated.*

Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented continued improvement in HgbA1C.

Dr. Couse motioned to accept the criteria, and Kellen Ludvigson seconded. All members were in favor.

Proton Pump Inhibitors: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is not required for preferred proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day. Requests for PPIs exceeding one unit per day for a diagnosis of gastroesophageal reflux disease will be considered after documentation of a therapeutic trial and therapy failure with concomitant use of once daily PPI dosing and a bedtime dose of a histamine H2-receptor antagonist. Upon failure of the combination therapy, subsequent requests for PPIs exceeding one unit per day will be considered on a short term basis (up to 3 months). After the three month period, a retrial of the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day.

Requests for twice daily dosing for a diagnosis of Helicobacter pylori will be considered for up to 14 days of treatment with documentation of an active infection.

Payment for a non-preferred proton pump inhibitor will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred products.

Kellen Ludvigson motioned to accept the criteria, and Dr. Wilbur seconded. All members were in favor.

Hepatitis C Protease Inhibitors: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for all oral hepatitis C protease inhibitors. Payment will be considered under the following conditions:

1. *A diagnosis of hepatitis C genotype 1, and*
2. *Patient is 18 years of age or older, and*
3. *Administered in combination with peg-interferon alfa and ribavirin.*
4. *HCV-RNA results are required at treatment week 4 for telaprevir (Incivek™). Additional prior authorization will be considered with documentation of response to treatment, measured by HCV-RNA levels. A maximum 12 weeks of therapy will be allowed for telaprevir (Incivek™).*

HCV-RNA results are required at treatment week 8, 12, and 24 (including lead in period) for boceprevir (Victrelis™). Additional prior authorizations will be considered with documentation of response to treatment, measured by HCV-RNA levels. Prior authorizations will be approved for a maximum of 24, 32, or 44 weeks of therapy with boceprevir (Victrelis™) based on response.

As this was the second review of these criteria, no motion was necessary. The recommendation will be sent to the Department for consideration.

Apixiban (Eliquis): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for apixaban (Eliquis®). Payment will be considered for patients under the following conditions:

1. *Patient has a diagnosis of non-valvular atrial fibrillation; and*
2. *Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial); and*
3. *Presence of at least one additional risk factor for stroke, with a $CHADS_2$ score ≥ 1; and*
4. *Patient does not have a mechanical prosthetic heart valve; and*
5. *Patient does not have active bleeding; and*
6. *Patient does not have severe renal impairment (CrCl < 15mL/min) or is not on dialysis.*

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

As this was the second review of these criteria, no motion was necessary. The recommendation will be sent to the Department for consideration.

Public Comment

There were no public comments.

Focus Studies

Duplicate Anxiolytics: This was a follow-up discussion. Ninety-six (96) of the 468 members identified changed therapy, for an annualized cost savings of $2,002.38 (state and federal, pre-rebate) as a result of the 1,296 surveys sent out to prescribers and pharmacies. A total of 504 (38.89%) surveys were returned.

Duplicate Sedative/Hypnotics: This was a follow-up discussion. Eighteen (18) of the

61 members identified changed therapy, for an annualized cost savings of $4,389.66 (state and federal, pre-rebate) as a result of the 152 surveys sent out to prescribers and pharmacies. A total of 48 (31.58%) surveys were returned.

Butalbital Utilization: This was a follow-up discussion. Five (5) of the 30 members identified changed therapy, for an annualized cost savings of $1,176.90 (state and federal, pre-rebate) as a result of the 76 surveys sent out to prescribers and pharmacies. A total of 23 (30.26%) surveys were returned. Data will be re-run to re-evaluate utilization, with results brought to the next meeting.

Three or More Anticonvulsants: Letters will be sent to the providers of the 27 members without a seizure/epilepsy diagnosis, and also the providers of the 296 members with a diagnosis, taking three or more AEDs to ask the rationale for use of multiple AEDs and if one or more of the AEDs could be discontinued.

Namenda Utilization: Letters will be sent to all the providers of members using memantine for a potential off-label diagnosis.

Cymbalta Daily Dose above 60mg without Depression Diagnosis: Letters will be sent to the providers of the members taking more than 120mg per day.

Miscellaneous

DUR Digest: The Commission member reviewed the draft for DUR Digest Volume 26, Number 2.

MedWatch: The Commission members received FDA announcements concerning new Black Box Warnings.

A unanimous vote was made at 11:25 to adjourn the meeting and move to closed session (motion by Larry Ambroson, second by Dr. Barclay).

The next meeting will be held at 9:30 a.m. on Wednesday, February 5, 2014, at the Learning Resource Center in West Des Moines.