MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE APRIL 14, 2016 MEETING

DUR Board Members:	Aug 2014	Nov 2014	Feb 2015	May 2015	Aug 2015	Nov 2015	Jan 2016	Apr 2016
Allison Bell, PharmD	✓		✓	✓	✓	✓	✓	✓
James R. "Beau" Cox, PharmD	✓		✓	✓	✓	✓	✓	✓
Logan Davis, PharmD	✓	✓	✓	✓	✓	✓	✓	✓
Antoinette M. Hubble, MD	✓	✓	✓	✓	✓	✓	✓	✓
Cherise McIntosh, PharmD	✓	✓	✓	✓		✓		✓
Jason Parham, MD	✓	✓	✓	✓	✓	✓	✓	✓
Bobby Proctor, MD	✓	✓		✓	✓	✓		✓
Janet Ricks, DO						✓	✓	
Sue Simmons, MD	✓		✓	✓	✓		✓	✓
Dennis Smith, RPh(Chair)	✓	✓	✓	✓	✓	✓	✓	✓
Cynthia Undesser, MD	✓		✓	✓	✓		✓	✓
Pearl Wales, PharmD						✓	✓	✓
TOTAL PRESENT	**11**	**6**	**9**	**10**	**9**	**10**	**10**	**11**

Mr. Smith arrived at 2:08
Dr. Parham arrived at 2:11

Also Present:

DOM Staff:
Terri Kirby, RPh, Interim Pharmacy Director, DOM; Cindy Noble, PharmD, MPH, DUR Coordinator, DOM; Dorthy Young, PhD, MHSA, Deputy Administrator for Health Services; Mary Katherine Ulmer, Medical Services Office Director; Tami Brooks, MD, DOM Medical Director; and Donna Mills, OMAP, Office of Medical Services

MS-DUR Staff:
Ben Banahan, PhD, MS-DUR Project Director; Shannon Hardwick, RPh, MS-DUR Clinical Director

Xerox State Healthcare Staff:
Leslie Leon, PharmD, Clinical Pharmacist, Mississippi Medicaid Project

Coordinated Care Organization Staff:
Conor Smith, MS, RPh, Director of Pharmacy, Magnolia Health
Michael Todaro, PharmD, Vice President, Pharmacy Operations, Magnolia Health

Visitors:
Wendy Phillabaum, Supernus; David Large, Supernus; Tim Hambacher, Otsuka; Jason Swartz, Otsuka; Steve Curry, Meda; John Kirby, Sanofi; Dan Barbera, Lilly; Alex Tabraue, ViiV Healthcare; Phil Hecht, Abbvie; Brian Bertlow, Sunovion; Florence Fraser, Pernix Therapeutics; Kelli Dulaney, UM-SOP student, Chelsey Bobo, UM-SOP student; Dr. Richard Olgetree, Pharm D; Clinical Assistant Professor, Pharmacy Practice, University of Mississippi Medical Center

Call to Order:
Pearl Wales, Co-Chair, called meeting to order at 2:03 pm.

Old Business:
Dr. Banahan indicated some corrective edits to address minor typos which were made to the draft January 21, 2016 minutes posted on the DOM website. Dr. Wales noted that her name was misspelled on page eight. Dr. Hubble moved to approve the minutes incorporating the above correction. The motion was seconded by Dr. McIntosh and approved unanimously.

Dr. Banahan requested an amendment to the agenda to add a review of non–preferred criteria for long-acting narcotics with abuse deterrent properties.

Pharmacy Program Update:
Ms. Kirby introduced Dr. Dorthy Young and recognized the DUR Board members, Drs. Cox, Davis, Parham, and Proctor, whose terms expire June 30, 2016. Ms. Kirby expressed her gratitude for their work and thanked them for their service to the state. Dr. Young also thanked the board members for their service to the state.

Ms. Kirby provided an overview of pharmacy reimbursement changes that are forthcoming as a result of the Affordable Care Act (ACA) Final Rule which addresses payment of Covered Outpatient Drugs in Medicaid programs. The Federal Upper Limits (FULs) have not been updated since 2009 but the new CMS rule provides for monthly updating. Ms. Kirby advised that DOM is working with pharmacy stakeholders during development of the new actual acquisition cost (AAC) based reimbursement methodology. Dr. Young expressed appreciation for the stakeholders' input during this process. She encouraged board members and others to utilize respective stakeholder representatives in their professional association organizations to provide input.

Feedback and Discussion from the Board
Dr. Cox asked that DOM review its policy of not covering insulin pens for beneficiaries residing in long term care (LTC) facilities. Dr. Cox has seen problems with accurate dosing in LTC and believes it is currently a safety issue not just a convenience issue. Ms. Kirby indicated that the decision to remove this restriction would rest with the Pharmacy and Therapeutics (P&T) Committee. She indicated that if data could be provided documenting safety issues in LTC, it could be taken back to P&T. Dr. Young suggested that the issue should be reviewed with DOM's Office of Long Term Care. Dr. Cox made the following motion:
DOM's policy restricting use of insulin pens in LTC should be taken back to the P&T committee for reconsideration.
The motion was seconded by Dr. McIntosh. After discussion, the motion was approved unanimously.

Resource Utilization Review:
Ms. Hardwick noted that eligibility data has stabilized following the transfer of children to the Coordinated Care Organizations (CCOs). Current enrollment has approximately 22% of beneficiaries with pharmacy benefits enrolled in FFS and approximately 39% in each of the CCOs. No unexpected or unexplained variations in product use were identified during the report period.

Utilization and Treatment Patterns for Pediculicides

Dr. Brooks, DOM Medical Director, provided a backgrounder on the potential problems being experienced by pediatricians and other primary care providers related to resistance when treating head lice. Ms. Hardwick reviewed results from a MS-DUR study. Dr. Hubble indicated that drug resistance is not anything new and that, in her experience, the OTC treatments need to be left on longer than indicated. Dr. Undesser stated that in her experience, residential care settings have definitely noted drug resistance from lice treatments. Dr. Noble reported that the Natroba step edit has been removed from the Universal Preferred Drug list (UPDL). Included in the DUR board packet was a chart summarizing current treatment options. Kelli Dulaney, a UM School of Pharmacy student, developed the chart while doing a rotation with Dr. Noble at DOM. Mr. Smith indicated that information about treatment options, treatment guidelines, use of gels, etc. would be helpful to him in his practice. Drs. Brooks and Simmons indicated that the chart summarizing products would be helpful for providers. Dr. Young stated that DOM cannot pay for provider education that is not related to products covered by Medicaid; however suggested working with United Healthcare and Magnolia regarding the educational chart summarizing the products. Dr. Noble advised the DUR Board that Medicaid does not cover hair gels and some of the treatments being discussed.

Proposed DUR Criteria for Managing Opioid Use and Minimizing Risk of Overdose

Dr. Banahan reminded the DUR Board that highlights of the proposed Draft CDC Guidelines for Prescribing Opioids for Chronic Pain were presented at the January 21, 2016 DUR Board meeting and that this topic would be a major agenda item for the April 14, 2016 DUR meeting. As the CDC guidelines are now finalized, each recommendation that could be addressed through DUR actions was reviewed by MS-DUR. Dr. Banahan described each CDC recommendation with results from an analysis of DOM data for fee-for-service and CCOs for the period of January – December 2015. The DUR Board was then asked for input on suggested actions for each of the following recommendations.

CDC recommendation 1: *When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.*

Dr. Banahan explained that new starts in therapy are typically identified by using a "wash out" period during which a beneficiary did not fill a prescription for the targeted therapy. MS-DUR identified new starts for narcotic therapy using a 60-day and 90-day wash out period. When using a 60-day period to define a new start, only 711 (0.70%) of beneficiaries had a new narcotic prescription fill that was not for a short-acting (SA) narcotic. This number decreased to 396 (0.46%) when using a 90-day period to define a new start. The analysis also found that SA opioids are not always being used before patients are transitioned to LA opioids and 14-18% of beneficiaries taking LA opioids are using them intermittently. After discussion, Dr. Bell made the following motion which was seconded by Dr. Simmons and passed unanimously.

a. New narcotic prescriptions (first narcotic fill within 90 days) for non-cancer patients must be for SA narcotics.

CDC recommendation 2: *When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.*

According to the CDC guidelines, most experts agreed that, in general, increasing dosages to $\geq$50 MME/day increases the risk of overdose without necessarily adding benefits for pain control or function. Clinicians should carefully reassess evidence of individual benefits and risks when considering increasing

opioid dosages to ≥50 MME/day. Most experts also agreed that opioid dosages should not be increased to ≥90 MME/day without careful justification based on diagnosis and on individualized assessment of benefits and risks. MS-DUR reported that in 2015, 23% of beneficiaries taking opioids had individual prescriptions written for ≥50 MEDD and 4.6% had individual prescriptions written for ≥90 MEDD. During the discussion, a board member asked that MS-DUR examine who and how many prescribers were writing the high MEDD prescriptions and conduct educational or other interventions if needed. After discussion, Dr. Hubble made the following motion, which was seconded by Dr. Wales and passed unanimously.

b. For non-cancer patients, individual prescriptions for opioids with a MEDD of ≥ 90 must require a manual PA with documentation that the benefits outweigh the risks and that the patient has been counseled about the risks of overdose and death.

CDC recommendation 3: *Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.*
The Board was asked for input on the issue of making naloxone available. During the discussion, a board member asked that MS-DUR run an analysis on the frequency of overdose and death related to opioid use. No specific DUR recommendations were made.

CDC recommendation 4: *Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.*
The MS-DUR 2015 analysis found that 72% of new starts for SA narcotic prescriptions were written for ≤ 7 days and 88% were written for ≤ 15 days. After discussion, Dr. McIntosh made the following motion, which was seconded by Dr. Bell and passed unanimously.

c. For non-cancer patients, new fills (first prescription fill in 90 days) for a SA opioid can be approved through an electronic PA for a maximum of two 7-day supplies. Use of SA opioids for longer periods will require a manual PA.

CDC recommendation 5: *Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible.*
According to the CDC guidelines, experts agreed that although there are circumstances when it might be appropriate to prescribe opioids to a patient receiving benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible. The MS-DUR analysis found that 5.3% of beneficiaries taking opioids were concurrently taking benzodiazepines. After discussion, Dr. Undesser moved that the following DUR actions be taken, which was seconded by Dr. McIntosh and approved unanimously.

d. Concomitant use of opioids and benzodiazepines should require a manual PA.
e. MS-DUR should provide an educational mailing to providers prescribing concurrent use of benzodiazepines and opioids to inform them of the increased safety risks and highlight the CDC recommendation to avoid concomitant use.

Review of Non-Preferred Criteria for Hysingla, Zohydro and Oxycontin (abuse deterrent opioids)
Dr. Banahan reviewed the current UPDL non-preferred criteria for the long-acting narcotics (opioids). Dr. Noble gave a backgrounder on recent changes in opioid formulations that have abuse-deterrent properties and highlighted the FDA's emphasis on use of abuse-deterrent products. Due to the existing, stricter PA criteria on these three products Dr. Noble suggested that PA criteria should be the same as the other non-preferred products.
Dr. Bell moved that products reformulated to have abuse-deterrent properties should not have additional non-preferred criteria applied beyond those for the class. The motion was seconded by Dr. Simmons. After discussion the motion was approved unanimously.

Next Meeting Information:

Mr. Smith announced that the next meeting date is scheduled for July 21, 2016 at 2:00 p.m. He thanked everyone for their attendance and participation at the April DUR Board meeting. The meeting adjourned at 4:02 pm.

Submitted,

Shannon Hardwick, RPh
Evidence-Based DUR Initiative, MS-DUR

MISSISSIPPI DIVISION OF
MEDICAID

Drug Utilization Review

Board Meeting

April 14, 2016

2:00 P.M.

Woolfolk Building - Room 117