Division of Medicaid
Office of the Governor
State of Mississippi
Drug Utilization Review (DUR) Board Meeting

MISSISSIPPI DIVISION OF
MEDICAID

September 29, 2016 at 2:00pm

Woolfolk Building, Room 117

Jackson, MS

Prepared by:

MS | DUR Evidence-Based DUR Initiative
The University of Mississippi School of Pharmacy

Drug Utilization Review Board

Allison Bell, PharmD
University of MS School of Pharmacy
2500 North State St.
Jackson, MS 39216
Term Expires: June 30, 2018

Craig L. Escudé, MD
Mississippi State Hospital
PO Box 97
Whitfield, MS 39193
Term Expires: June 30, 2019

Juanice Glaze, RPh
Wal-Mart Pharmacy
5901 U.S. Highway 49
Hattiesburg, MS 39402
Term Expires: June 30, 2019

Antoinette M. Hubble, MD
McComb Children's Clinic
300 Rawls Dr. Ste 100
McComb, MS 39648
Term Expires: June 30, 2017

Cherise McIntosh, PharmD
UMC Dept of Pharmacy
2500 North State St.
Jackson, MS 39216
Term Expires: June 30, 2017

Alice F. Messer, FNP-BC
Newsouth Neurospine
2470 Flowood Drive
Flowood, MS 39232
Term Expires: June 30, 2019

Janet Ricks, DO
UMMC, Family Medicine
2500 North State Street
Jackson, MS 39216
Term Expires: June 30, 2018

Sue H. Simmons, MD
Maben Medical Clinic
49 Turner St.
Maben, MS 39750
Term Expires: June 30, 2018

Dennis Smith, RPh (**Chair**)
Polk's Discount Pharmacy
1031 Star Rd
Brandon, MS 39042
Term Expires: June 30, 2017

James Taylor, PharmD
North MS Medical Center
830 S. Gloster Street
Tupelo, MS 38801
Term Expires: June 30, 2019

Cynthia Undesser, MD
MS Children's Home Services
402 Wesley Ave
Jackson, MS 39202
Term Expires: June 30, 2017

Pearl Wales, PharmD
Be Jay PE Pharmacy 1668
West Peace Street
Canton, MS 39047
Term Expires: June 30, 2018

2017 DUR Board Meeting Dates

February 2, 2017
April 27, 2017
July 27, 2017
November 2, 2017

As with any analysis, great efforts are made to ensure that the information reported in this document is accurate. The most recent administrative claims data available are being used at the time the reports are generated, which includes the most recent adjudication history. As a result, values may vary between reporting periods and between DUR Board meetings, reflecting updated reversals and claims adjustments.

Unless otherwise indicated, all MS-DUR analyses are conducted for the entire Mississippi Medicaid program including beneficiaries receiving services through the Medicaid fee-for-service (FFS) and the two Mississippi Medicaid Coordinated Care Organizations (CCOs). When dollar figures are reported, the reported dollar figures represent reimbursement amounts paid to providers and are not representative of final Medicaid costs after rebates. Any reported enrollment data presented are unofficial and are only for general information purposes for the DUR Board.

Please refer to the Mississippi Division of Medicaid website for the current official Universal Preferred Drug List (PDL).

http://www.medicaid.ms.gov/providers/pharmacy/preferred-drug-list/

MISSISSIPPI DIVISION OF MEDICAID
OFFICE OF THE GOVERNOR
DRUG UTILIZATION REVIEW BOARD
AGENDA
September 29, 2016

DUR Board Meeting Minutes

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 ≥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

MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE JULY 21, 2016 MEETING

DUR Board Members:	Nov 2014	Feb 2015	May 2015	Aug 2015	Nov 2015	Jan 2016	Apr 2016	Jul 2016
Allison Bell, PharmD		✓	✓	✓	✓	✓	✓	
Antoinette M. Hubble, MD	✓	✓	✓	✓	✓	✓	✓	✓
Cherise McIntosh, PharmD	✓	✓	✓		✓		✓	
Janet Ricks, DO					✓	✓		
Sue Simmons, MD		✓	✓	✓		✓	✓	
Dennis Smith, RPh(Chair)	✓	✓	✓	✓	✓	✓	✓	
Cynthia Undesser, MD		✓	✓	✓		✓	✓	✓
Pearl Wales, PharmD					✓	✓	✓	✓
TOTAL PRESENT	**6**	**9**	**10**	**9**	**10**	**10**	**11**	**3**

NOTE: Only eight members are listed due to new appointments to DUR Board not being approved by Governor prior to meeting.

Also Present:

Division of Medicaid (DOM) Staff:
Terri Kirby, RPh, CPM, Pharmacy Director, DOM; Cindy Noble, PharmD, MPH, DUR Coordinator, DOM

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; Lew Anne Snow, RN BSN, Pharmacy Services Sr. Analyst, Mississippi Medicaid Project

Coordinated Care Organization Staff:
Michael Todaro, PharmD, Vice President, Pharmacy Operations, Magnolia Health

Visitors:
Alice Messer, FNP-BC, NewSouth NeuroSpine Pain Center; Craig Escude ,MD, Clinical Director, Hudspeth Regional Center; Rusty Perkins, Lundbeck Pharmaceutical; Wendy Phillabaum, Supernus; Steve Curry, Meda; John Kirby, Sanofi; Dan Barbera, Lilly; Phil Hecht, Abbvie; Lillie Floyd, UM-SOP student, Theresa Deterding, UM-SOP student; Kris Kinser, UM-SOP student; Richard Olgetree, PharmD, University of Mississippi Medical Center; Jeff Stockard, Walgreens; Pat Harvey, Walgreens; Leigh Turner, Indivior.

Call to Order:
Dr. Wales, Co-Chair, called the meeting to order at 2:04 pm. She announced there was not a quorum present for the meeting, therefore, no official business could be conducted. Dr. Wales introduced Alice Messer, FNP and Craig Escude, MD, as nominees for appointment to the DUR Board.

Old Business:
Minutes from the April 2016 DUR Board Meeting could not be approved due to lack of a voting quorum. The members present did not note any corrections to the minutes.

Pharmacy Program Update:
Ms. Kirby informed the board that on June 1, 2016 the Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin informing Medicaid Agencies how Medicaid services can help states and territories prevent, detect, and respond to the Zika virus. In response to this bulletin, effective August 1, 2016, DOM will cover mosquito repellents when prescribed by an enrolled Medicaid provider and billed by a Medicaid pharmacy provider. DOM will maintain a list of covered insect repellents which have been assigned National Drug Code (NDC) numbers by national drug databases such as First Databank and Medispan and will include reimbursement amounts. This list should be posted to DOM's website and an informational article will be included in DOM's next bulletin. Prescription claims for insect repellents will not count toward the five (5) prescription monthly service limit. A maximum of two (2) cans/bottles per month per beneficiary will be allowed for all male and female beneficiaries ages 13 and older.

Ms. Kirby also noted that beginning October 1, 2016, Goold Health Systems (name will be Change Healthcare in the future), the current vender for DOM's uniform PDL and P&T meetings, will also become the vendor for prior authorization (PA) unit. Ms. Kirby noted the change from the existing PA unit at University of Mississippi Medical Center to GHS should be a fairly seamless process for providers since all the contact numbers for phone and fax will remain the same for DOM's PA unit as well as access to the web portal. Ms. Kirby advised there was a pharmacy stakeholder meeting last month to address the new reimbursement methodology and that all members were in agreement to use NADAC. There will be additional stakeholder meetings in the near future to propose reimbursement methodology for specialty drugs as well as hemophilia drugs. Ms. Kirby mentioned that her previous job position in DOM has now been posted and she encouraged anyone who knows a qualified applicant to inform them of the available pharmacist position.

Dr. Noble introduced and welcomed Kris Kisner, a student with the School of Pharmacy currently on a clinical pharmacy rotation with DOM. Dr. Noble also welcomed Lillie Floyd and Theresa Deterding, students with the School of Pharmacy currently on rotation with Dr. Olgetree at the University of Mississippi Medical Center. Dr. Noble asked Dr. Banahan to give an overview of MS-DUR's job and responsibilities.

Feedback and Discussion from the Board
Dr. Hubble advised that ofloxacin has not been available due to a backorder status and she would like to prescribe Ciprodex until ofloxacin availability resumes. Dr. Hubble asked Ms. Kirby if the age edit of 14 years associated with Ciprodex could be removed to avoid going through the manual PA process. Ms. Kirby acknowledged Dr. Hubble's request and advised she would look into the situation when she returned to the DOM office.

Resource Utilization Review:
Ms. Hardwick noted that eligibility data has remained stable with 21.7 % 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. Ms. Hardwick advised that there is missing data from United Healthcare for the month of April. Dr. Banahan reviewed the new table format being developed for the resource utilization reports.

Research Reports:

Review of Buprenorphine/Naloxone Therapy and Current Clinical Criteria

Dr. Banahan provided a backgrounder on the current DOM clinical criteria for the use of buprenorphine/naloxone and naloxone in the treatment of opioid dependency. Implemented September 1, 2012, it addressed the following elements:

- Diagnosis documenting treatment of opioid dependence required.
- Buprenorphine will only be approved for use during pregnancy and breastfeeding.
- Cumulative maximum of 24 months of therapy covered.
- Only one restart of therapy allowed.
- Step therapy with maximum daily doses for each month of therapy.
- Opioid use restrictions.

Dr. Banahan reminded the board of the various initiatives from the Department of Health and Human Services (DHHS), the Centers for Disease Control (CDC), and others to address the opioid abuse "epidemic." It was noted that an important component in most of these initiatives has been the increased use of medication assisted treatment (MAT) for opioid use disorders. Buprenorphine/naloxone and buprenorphine are one of the few FDA approved treatments for opioid dependence. It was noted that with the increased focus on MAT and the need to treat opioid abuse more effectively, the restrictions often used to manage utilization of buprenorphine/naloxone treatment are being questioned by some organizations.

Dr. Banahan summarized an MS-DUR analysis examining buprenorphine/naloxone and buprenorphine utilization since September 2012. Major findings were:

- Almost all use has been for the preferred products.
- A fairly high percentage of beneficiaries had daily doses that exceeded the 8mg/day limit during maintenance therapy.
- The maximum of 24 cumulative months of therapy did not appear to be a problem, except when beneficiaries had switched pharmacy programs.
- The limit on the number of restarts did not appear to be a problem, except when beneficiaries had switched pharmacy programs.
- Only 12% of beneficiaries exceeded the opioid restrictions during therapy, but almost all of these beneficiaries continued buprenorphine/naloxone therapy for more than 30 days after exceeding the criteria.

During discussion the following follow-up analyses were identified to help in evaluating the current guidelines.

- Is the same provider writing prescriptions for initial therapy and restarts?
- How often are beneficiaries paying cash in order to be treated with higher doses than the DOM guidelines allow?
- How often are PAs for daily doses that exceed the guidelines being denied?

Preliminary Analysis of Payment Source for Narcotic Claims BY Mississippi Medicaid Beneficiaries

Dr. Banahan reported that MS-DUR has obtained the Prescription Monitoring Program data for Medicaid beneficiaries for the period April 1, 2014 through April 30, 2016. Preliminary results of cash payments for narcotics were shared with the board. Dr. Banahan described the data cleaning and validation

process that is underway and outlined the planned analyses to address the impact of cash payments on drug utilization management efforts.

Use of Multiple Antipsychotics in Children

Dr. Noble presented background information on DOM's efforts to develop a manual PA form for the use of two or more atypical antipsychotics in children. MS-DUR will present results at the September 2016 DUR Board meeting on the number of beneficiaries and providers that would be affected by the new edit.

Next Meeting Information:

Dr. Wales announced that the next meeting date is scheduled for September 29, 2016 at 2:00 p.m. She thanked everyone for their attendance and participation at the July DUR Board meeting. The meeting adjourned at 4:10 pm.

Submitted,

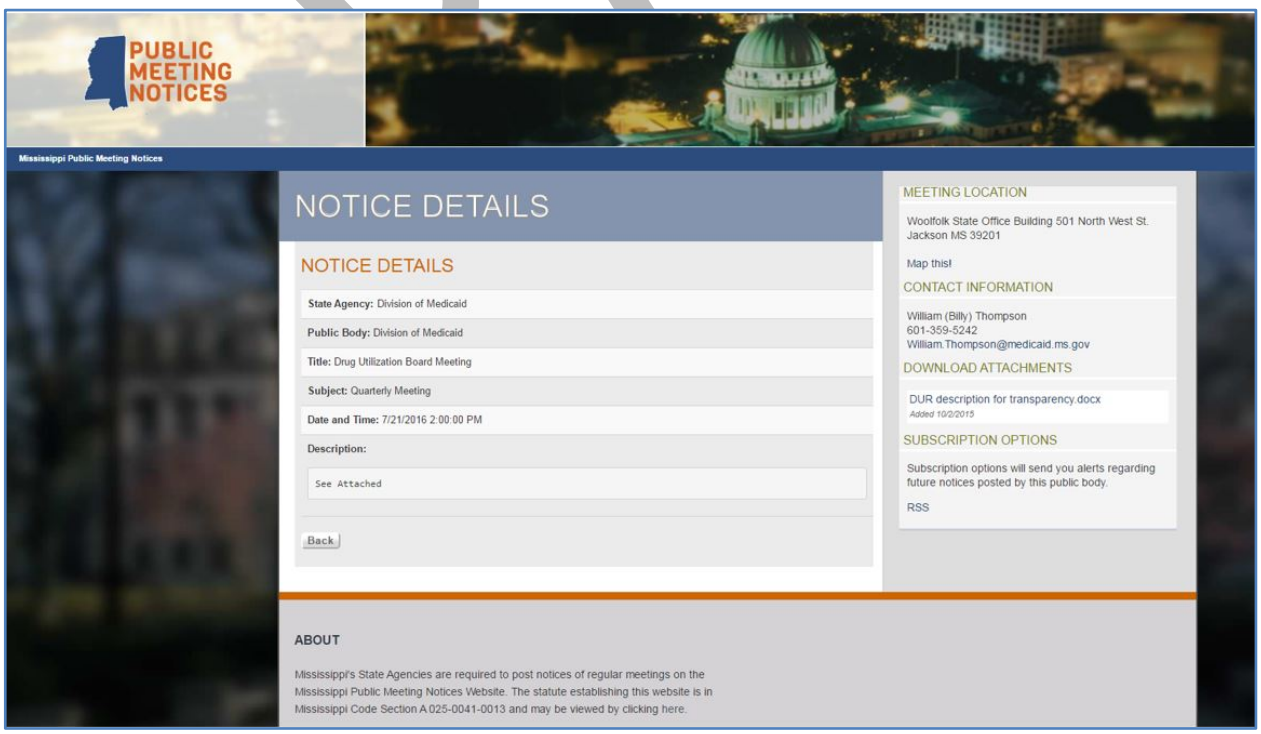
Shannon Hardwick, RPh
Evidence-Based DUR Initiative, MS-DUR

PUBLIC NOTICES ABOUT MEETING

MISSISSIPPI DIVISION OF
MEDICAID

Drug Utilization Review
Board Meeting

July 21, 2016
2:00 P.M.
Woolfolk Building - Room 117



Resource Utilizaton Review

TABLE 04A: ENROLLMENT STATISTICS FOR LAST 6 MONTHS
February 1, 2016 through July 31, 2016

			Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Total enrollment			753,516	753,801	753,112	751,592	749,039	743,353
Dual-eligibles			155,831	155,838	155,480	155,121	154,681	154,241
Pharmacy benefits			648,015	647,823	646,651	644,912	642,244	636,251
	LTC		17,325	17,418	17,385	17,446	17,349	17,125
	PLAN %	FFS	21.9%	21.7%	22.3%	21.3%	21.0%	21.0%
		MSCAN-UHC	38.9%	39.0%	38.7%	39.2%	39.4%	39.4%
		MSCAN-Magnolia	39.2%	39.3%	39.0%	39.5%	39.6%	39.6%

TABLE 04B: PHARMACY UTILIZATION STATISTICS FOR LAST 6 MONTHS
February 1, 2016 through July 31, 2016

		Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
# Rx Fills	FFS	93,155	96,431	95,860	88,300	84,797	81,725
	MSCAN-UHC	212,204	217,753	166,914	157,078	181,872	173,493
	MSCAN-Mag	241,173	249,326	238,193	224,188	211,248	201,021
# Rx Fills / Bene	FFS	0.7	0.7	0.7	0.6	0.6	0.6
	MSCAN-UHC	0.8	0.9	0.7	0.6	0.7	0.7
	MSCAN-Mag	0.9	1.0	0.9	0.9	0.8	0.8
$ Paid Rx	FFS	$13,341,984	$13,978,042	$12,398,284	$11,531,467	$11,185,948	$11,019,863
	MSCAN-UHC	$19,523,351	$20,597,276	$14,320,624	$12,007,267	$14,527,724	$13,856,000
	MSCAN-Mag	$21,615,604	$23,074,611	$19,263,120	$17,292,117	$16,634,171	$15,692,485
$ /Rx Fill	FFS	$143.22	$144.95	$129.34	$130.59	$131.91	$134.84
	MSCAN-UHC	$92.00	$94.59	$85.80	$76.44	$79.88	$79.86
	MSCAN-Mag	$89.63	$92.55	$80.87	$77.13	$78.74	$78.06
$ /Bene	FFS	$94.01	$99.43	$85.98	$83.95	$82.94	$82.48
	MSCAN-UHC	$77.45	$81.52	$57.22	$47.50	$57.41	$55.27
	MSCAN-Mag	$85.09	$90.63	$76.38	$67.88	$65.40	$62.28

NOTE: Paid amounts represent amount reported on claims as paid to the pharmacy. These amounts do not reflect final actual costs after rebates, etc.

TABLE 04C: TOP 10 DRUG CATEGORIES BY NUMBER OF CLAIMS IN JULY 2016 (FFS AND CCOs)

Category	Month Year	Rank Volume	# RXs	$ Paid	# Unique Benes
narcotic analgesic combinations	July 201	1	23,990	$517,254	21,826
	June 201	1	25,935	$566,126	23,413
	May 2016	1	23,233	$509,862	21,225
CNS stimulants	July 201	2	19,572	$4,196,232	17,127
	June 201	2	20,087	$4,315,083	17,368
	May 2016	2	21,082	$4,494,026	18,525
nonsteroidal anti-inflammatory agents	July 201	3	14,618	$218,046	14,026
	June 201	3	15,255	$204,216	14,622
	May 2016	3	14,347	$191,244	13,816
adrenergic bronchodilators	July 201	4	12,803	$1,297,225	11,039
	June 201	5	12,952	$1,189,951	11,341
	May 2016	5	13,438	$1,096,107	11,820
antihistamines	July 201	5	11,728	$265,015	11,321
	June 201	4	13,142	$294,506	12,669
	May 2016	4	14,320	$327,744	13,900
SSRI antidepressants	July 201	6	11,213	$91,935	10,642
	June 201	8	11,473	$95,413	10,815
	May 2016	8	10,723	$98,445	10,155
atypical antipsychotics	July 201	7	11,181	$2,240,605	9,963
	June 201	7	11,475	$2,519,695	10,122
	May 2016	7	10,873	$2,656,440	9,685
aminopenicillins	July 201	8	10,824	$102,243	10,608
	June 201	6	12,186	$117,980	11,960
	May 2016	6	13,282	$132,973	13,070
proton pump inhibitors	July 201	9	10,518	$477,592	10,197
	June 201	9	10,684	$503,869	10,340
	May 2016	12	10,100	$521,142	9,808
leukotriene modifiers	July 201	10	9,437	$423,207	9,259
	June 201	10	9,880	$475,003	9,690
	May 2016	10	10,210	$463,775	10,062

TABLE 04D: TOP 10 DRUG CATEGORIES BY DOLLARS PAID IN JULY 2016 (FFS AND CCOs)

Category	Month Year	Rank Paid Amt	# RXs	$ Paid	# Unique Benes
CNS stimulants	July 201	1	19,572	$4,196,232	17,127
	June 201	1	20,087	$4,315,083	17,368
	May 2016	1	21,082	$4,494,026	18,525
antiviral combinations	July 201	2	730	$2,738,858	705
	June 201	2	736	$2,832,106	696
	May 2016	2	691	$2,732,897	664
factor for bleeding disorders	July 201	3	98	$2,420,840	85
	June 201	4	102	$2,374,318	82
	May 2016	4	92	$2,601,872	69
insulin	July 201	4	4,538	$2,293,716	3,411
	June 201	5	4,626	$2,291,073	3,512
	May 2016	5	4,301	$2,096,898	3,300
atypical antipsychotics	July 201	5	11,181	$2,240,605	9,963
	June 201	3	11,475	$2,519,695	10,122
	May 2016	3	10,873	$2,656,440	9,685
adrenergic bronchodilators	July 201	6	12,803	$1,297,225	11,039
	June 201	6	12,952	$1,189,951	11,341
	May 2016	6	13,438	$1,096,107	11,820
antirheumatics	July 201	7	302	$1,150,705	278
	June 201	7	298	$1,091,680	281
	May 2016	7	261	$900,553	241
bronchodilator combinations	July 201	8	2,913	$884,931	2,719
	June 201	8	2,864	$867,904	2,670
	May 2016	9	2,765	$833,484	2,588
gamma-aminobutyric acid analogs	July 201	9	8,464	$804,125	7,959
	June 201	11	8,680	$778,371	8,098
	May 2016	11	8,187	$692,355	7,700
inhaled corticosteroids	July 201	10	2,437	$730,455	2,399
	June 201	10	2,621	$815,497	2,580
	May 2016	8	2,695	$844,783	2,655

TABLE 04E: TOP 25 DRUG MOLECULES BY NUMBER OF CLAIMS IN JULY 2016 (FFS and CCOs)

Drug Molecule Therapeutic Category	Jun 2016 # Claims	Jul 2016 # Claims	Jul 2016 $ Paid	Jul 2016 # Unique Benes
acetaminophen-hydrocodone / narcotic analgesic combinations	18,398	16,954	$185,671	15,744
albuterol / adrenergic bronchodilators	12,167	11,831	$699,720	10,326
amoxicillin / aminopenicillins	12,093	10,710	$101,015	10,496
montelukast / leukotriene modifiers	9,876	9,435	$422,724	9,257
cetirizine / antihistamines	8,362	7,458	$172,616	7,336
gabapentin / gamma-aminobutyric acid analogs	7,280	7,050	$100,835	6,698
omeprazole / proton pump inhibitors	7,232	6,998	$49,839	6,842
amlodipine / calcium channel blocking agents	6,928	6,798	$24,812	6,611
lisdexamfetamine / CNS stimulants	6,404	6,420	$1,688,025	6,258
ibuprofen / nonsteroidal anti-inflammatory agents	6,770	6,419	$56,648	6,292
azithromycin / macrolides	7,308	6,372	$113,212	6,213
sulfamethoxazole-trimethoprim / sulfonamides	5,883	5,903	$123,484	5,810
mupirocin topical / topical antibiotics	5,013	5,422	$70,478	5,287
clonidine / antiadrenergic agents, centrally acting	5,363	5,226	$112,730	4,967
amphetamine-dextroamphetamine / CNS stimulants	5,438	5,147	$582,540	4,452
lisinopril / angiotensin converting enzyme inhibitors	4,963	4,796	$13,101	4,676
methylphenidate / CNS stimulants	4,921	4,733	$1,038,930	4,300
fluticasone nasal / nasal steroids	4,940	4,627	$254,882	4,588
ethinyl estradiol-norgestimate / contraceptives	4,452	4,420	$73,305	4,147
triamcinolone topical / topical steroids	4,557	4,093	$66,827	3,963
metformin / biguanides	4,061	3,883	$70,690	3,756
amoxicillin-clavulanate / penicillins/beta-lactamase inhibitors	4,630	3,801	$179,337	3,741
ranitidine / H2 antagonists	3,730	3,784	$186,121	3,663
guanfacine / antiadrenergic agents, centrally acting	3,889	3,745	$116,537	3,567
alprazolam / benzodiazepines	3,977	3,726	$19,222	3,615

TABLE 04F: TOP 25 DRUG MOLECULES
BY DOLLARS PAID IN JULY 2016 (FFS and CCOs)

Drug Molecule Therapeutic Category	Jun 2016 $ Paid	Jul 2016 $ Paid	Jul 2016 # Claims	Jul 2016 # Unique Benes
lisdexamfetamine / CNS stimulants	$1,685,471	$1,688,025	6,420	6,258
ledipasvir-sofosbuvir / antiviral combinations	$1,463,659	$1,330,599	40	37
anti-inhibitor coagulant complex / factor for bleeding disorders	$827,490	$1,115,795	6	6
antihemophilic factor / factor for bleeding disorders	$1,031,859	$1,074,937	38	27
methylphenidate / CNS stimulants	$1,080,550	$1,038,930	4,733	4,300
aripiprazole / atypical antipsychotics	$1,003,496	$822,588	2,421	2,291
insulin glargine / insulin	$841,699	$818,042	1,805	1,733
albuterol / adrenergic bronchodilators	$708,699	$699,720	11,831	10,326
adalimumab / antirheumatics	$700,932	$691,646	132	122
insulin aspart / insulin	$579,876	$636,994	1,198	1,135
somatropin / growth hormones	$702,744	$608,707	146	138
amphetamine-dextroamphetamine / CNS stimulants	$627,145	$582,540	5,147	4,452
epinephrine / adrenergic bronchodilators	$454,420	$573,550	901	893
pregabalin / gamma-aminobutyric acid analogs	$561,752	$567,249	1,404	1,358
sofosbuvir / miscellaneous antivirals	$827,932	$502,674	17	17
lurasidone / atypical antipsychotics	$479,759	$490,336	445	419
deferasirox / chelating agents	$520,630	$479,881	57	54
budesonide / inhaled corticosteroids	$544,758	$460,340	995	978
dexmethylphenidate / CNS stimulants	$440,591	$452,804	2,201	1,882
efavirenz/emtricitabine/tenofovir / antiviral combinations	$457,722	$450,546	181	179
montelukast / leukotriene modifiers	$474,038	$422,724	9,435	9,257
quetiapine / atypical antipsychotics	$481,560	$386,939	2,917	2,611
fluticasone-salmeterol / bronchodilator combinations	$357,848	$358,888	989	977
insulin detemir / insulin	$375,455	$352,898	730	699
etanercept / antirheumatics	$305,336	$350,940	82	77

TABLE 04 G: TOP 15 DRUG SOLID DOSAGE FORM HIGH VOLUME (100+ RX FILLS LAST MONTH) PRODUCTS WITH UNIT COST > $1
BY PERCENT CHANGE IN AMOUNT PAID PER UNIT MAY 2016 TO JULY 2016 (FFS and CCOs)

Drug Product Therapeutic Category	Jul 2016 # Claims	Jul 2016 $ Paid	Jul 2016 Avr. Paid Per Rx	Jul 2016 Avr. Units Per Rx	May 2016 Paid Per Unit	Jun 2016 Paid Per Unit	Jul 2016 Paid Per Unit	Percent Change
naproxen sodium 550 mg tablet / nonsteroidal anti-inflammatory agents	841	$73,108	$86.93	34	$1.80	$1.88	$2.41	33.8%
nitrofurantoin macrocrystals-monohydrate 100 mg capsule / urinary anti-infectives	1,467	$43,930	$29.95	16	$1.23	$1.17	$1.61	30.7%
Adderall XR (amphetamine-dextroamphetamine) 15 mg capsule, extended release / CNS stimulants	368	$77,981	$211.90	30	$6.04	$6.33	$6.93	14.8%
Adderall XR (amphetamine-dextroamphetamine) 10 mg capsule, extended release / CNS stimulants	340	$71,853	$211.33	30	$6.11	$6.35	$6.88	12.5%
Relpax (eletriptan) 40 mg tablet / antimigraine agents	120	$35,553	$296.28	6	$44.27	$49.39	$49.61	12.1%
Strattera (atomoxetine) 40 mg capsule / CNS stimulants	215	$90,456	$420.73	30	$12.66	$13.69	$14.03	10.8%
Strattera (atomoxetine) 60 mg capsule / CNS stimulants	139	$58,559	$421.29	30	$12.69	$13.85	$14.05	10.7%
fentanyl 50 mcg/hr film, extended release / narcotic analgesics	133	$11,218	$84.35	10	$7.51	$8.68	$8.25	9.9%
Strattera (atomoxetine) 25 mg capsule / CNS stimulants	181	$71,294	$393.89	31	$11.74	$12.75	$12.86	9.6%
Zetia (ezetimibe) 10 mg tablet / cholesterol absorption inhibitors	106	$31,754	$299.56	30	$9.05	$9.18	$9.90	9.4%
clarithromycin 500 mg tablet / macrolides	224	$6,942	$30.99	23	$1.03	$1.13	$1.11	7.8%
phenazopyridine 200 mg tablet / miscellaneous genitourinary tract agents	262	$8,203	$31.31	12	$2.06	$2.23	$2.21	7.3%
Adderall XR (amphetamine-dextroamphetamine) 30 mg capsule, extended release / CNS stimulants	632	$125,203	$198.11	31	$5.95	$6.45	$6.33	6.5%
Focalin XR (dexmethylphenidate) 25 mg capsule, extended release / CNS stimulants	186	$65,645	$352.93	31	$10.82	$10.84	$11.49	6.2%
Adderall XR (amphetamine-dextroamphetamine) 20 mg capsule, extended release / CNS stimulants	649	$138,367	$213.20	32	$6.06	$6.30	$6.39	5.5%

New Business

Special Analysis Projects

BENZODIAZEPINE UTILIZATION FOR INSOMNIA

BACKGROUND

Sleep related disorders are common in the general adult population. Researchers are finding that sleep disruption is often the result of the increased presence of medical, and psychosocial comorbidities in this population.[1] Drug therapies approved by the FDA for treatment of insomnia include benzodiazepines, non-benzodiazepines, melatonin receptor agonists, antidepressants, and orexin cycle antagonists.

According to the Maine Benzodiazepine Study Group guidelines, there is evidence for the effectiveness of benzodiazepines and other sedative hypnotics in the relief of short-term (1 to 2 weeks), but not long-term, insomnia. These guidelines recommend that the treatment period should not exceed 2 weeks.[1]

A review of the risks and benefits of benzodiazepines was conducted by the Psychopharmacology Special Interest Group of the Royal College of Psychiatrists and the British Association for Psychopharmacology. This group issued a joint statement with recommendations for the use of benzodiazepines in clinical practice.[2] They concluded that adequate treatment of insomnia is often difficult, and depends on many factors such as age, presence of physical illness, pain, use of concomitant medication(s), and history of drug or alcohol misuse. The adoption of 'sleep hygiene' techniques was considered to be the initial part of management. Benzodiazepines and at that time, the newer 'Z-drugs' (zaleplon, zolpidem and zopiclone) were recognized as the most effective drugs for the short-term treatment of insomnia that is severe, disabling and causing distress. As in the treatment of patients with anxiety disorders, it was recommended that the use of benzodiazepines should generally be limited to a maximum of four weeks. It was noted that in the United Kingdom, though not in the United States, all hypnotics are licensed for short term use only. The guidelines state that prescriptions for benzodiazepines should preferably be at the lowest effective dose and given intermittently. In patients with chronic insomnia, benzodiazepines should be used only in the short term while more appropriate longer-term treatments are started.

There are four benzodiazepines that are only indicated for use as sedative hypnotics for the treatment of insomnia: estazolam (Prosom®), flurazepam (Dalmane®), temazepam (Restoril®), and triazolam (Halcion®). Temazepam and triazolam are **only** indicated for short term treatment of insomnia (generally 7-10 days).

This report focuses on the utilization of benzodiazepines in the adult population for the Mississippi Division of Medicaid (DOM). The DUR Board reviewed utilization of triazolam at the meeting in August 2015.

[1] Maine Benzodiazepine Study Group. Guidelines for The Use of Benzodiazepines in Office Practice in The State of Maine. http://www.benzos.une.edu/documents/prescribingguidelines3-26-08.pdf accessed 9/12/2016.

[2] Baldwin DS, Aitchison K, Bateson A, et. al. Benzodiazepines: Risks and benefits. A reconsideration. *Journal of Psychopharmacology* 27(11) 967–971. 2013. DOI: 10.1177/0269881113503509.

Guidance on usage and length of therapy from triazolam prescribing information include:

Indications and Usage for Triazolam

Triazolam Tablets USP, are indicated for the short-term treatment of insomnia (generally 7 to 10 days). Use for more than 2 to 3 weeks requires complete reevaluation of the patient (see WARNINGS).

Prescriptions for Triazolam should be written for short-term use (7 to 10 days) and it should not be prescribed in quantities exceeding a 1-month supply.

Warnings

Because sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. **The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated.** Worsening of insomnia or the emergence of new thinking or behavior abnormalities may be the consequence of an unrecognized psychiatric or physical disorder. Such findings have emerged during the course of treatment with sedative-hypnotic drugs. Because some of the important adverse effects of sedative-hypnotics appear to be dose related (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), it is important to use the smallest possible effective dose, especially in the elderly.

Based on recommendations from the DUR Board, DOM implemented quantity limits for triazolam as indicated in the current Universal Preferred Drug List (UPDL).

SEDATIVE HYPNOTICS			
	BENZODIAZEPINES		
	estazolam flurazepam temazepam (15mg and 30mg)	DALMANE (flurazepam) DORAL (quazepam) HALCION (triazolam) RESTORIL (temazepam) temazepam (7.5mg and 22.5mg) triazolam	Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs. **Quantity Limits – CUMULATIVE** Quantity limit per rolling days for all strengths. *SmartPA will allow an early refill override for one dose or therapy change per year.* • **31 units/31 days** - all strengths **Triazolam – CUMULATIVE** Quantity limit per rolling days for all strengths • **10 units/31 days** • **60 units/365 days**

Temazepam has a similar indication as triazolam for short-term use when treating insomnia.

Indications and Usage for Temazepam

Temazepam Capsules, USP are indicated for the short-term treatment of insomnia (generally 7 to 10 days).
For patients with short-term insomnia, instructions in the prescription should indicate that Temazepam Capsules, USP should be used for short periods of time (7 to 10 days).
The clinical trials performed in support of efficacy were 2 weeks in duration with the final formal assessment of sleep latency performed at the end of treatment.

This report provides an update on triazolam utilization after implementation of new quantity limits criteria and examines utilization patterns for all benzodiazepines with insomnia indications only.

METHODS

In order to accurately reflect current prescribing patterns, a retrospective analysis was conducted using MS Medicaid pharmacy claims for all programs (fee-for-service (FFS) and coordinated care organizations (CCOs)) for the period January through July, 2016. All claims for benzodiazepines listed for sedative hypnotic use in the Universal Preferred Drug List were extracted (estazolam, quazepam, temazepam, and triazolam) and utilization patterns were examined.

RESULTS

Although three benzodiazepines are listed as preferred products in the UPDL, almost all utilization was for temazepam (Table 1) within all three pharmacy programs (fee-for-service (FFS), United Healthcare (UHC), and Magnolia).

Table 1: Number of Beneficiaries Taking Benzodiazepines With Insomina Indication
(January - July, 2016 -- FFS and CCOs)

	Pharmacy Program			
Product	FFS	United HealthCare	Magnolia	Total for Product
estazolam	1	2	0	3
flurazepam	1	3	5	9
temazepam	132	361	486	979
triazolam	1	15	5	21
quazepam	0	0	0	0
Total for Program	135	381	496	1012

NOTE: generic estraolam, flurazepam, and temazepam (15mg and 30mg) are preferred products on the Universal Preferred Drug List.

Table 2: Characteristics of Beneficiaries Taking Benzodiazepines With Insominia Indications
(January - July, 2016 -- FFS and CCOs)

Characteristic		Number	Percent
Gender	Female	733	72.4%
	Male	279	27.6%
Race	Caucasian	523	51.7%
	African Amer	376	37.2%
	Hispanic	6	0.6%
	Amer Indian	2	0.2%
	Other/Unknown	105	10.4%
Age	1 - 17	10	1.0%
	18 - 44	425	42.0%
	45 - 64	560	55.3%
	65+	17	1.7%

A total of 1,012 unique beneficiaries were treated with these benzodiazepines during the first half of 2016.

These beneficiaries were predominately female (72%) and adults 18-64 years of age (97.3%) (Table 2).

Table 3 shows the maximum number of days of continuous therapy for beneficiaries being treated with these sedative hypnotics. Patients were considered to be on continuous therapy if they had refilled prescriptions for the same product, with no more than a 15-day gap in supply between prescription fills.

Table 3: Maximum Number of Days Continous Therapy With Benzodiazepines Having Insominia Indications

(January - July, 2016 -- FFS and CCOs)

	Maximum Days Continous Therapy*							
Product	1-10	11-20	21-31	32 - 62	63 - 93	94 - 186	187 +	Total
estazolam	0	0	2	0	0	0	1	3
flurazepam	0	0	5	3	1	0	0	9
temazepam	9	65	432	233	95	74	71	979
triazolam	17	1	2	1	0	0	0	21

** Continous therapy was calcuated as date of first fill to date of last fill plus days supply for last fill, allowing for a 15 day refill gap.*

NOTE: Results include all beneficiaries filling prescriptions in 2016. Beneficiaries may have started therapy before January 2016 and may have started therapy just prior to the July 2016 end data for inclusion in the analyses.

Table 4 depicts the maximum number of days of therapy for beneficiaries during this 7-month period.

Table 4: Total Days of Therapy With Benzodiazepines Having Insominia Indications

(January - July, 2016 -- FFS and CCOs)

	Total Days of Therapy							
Product	1-10	11-20	21-31	32 - 62	63 - 93	94 - 186	187 +	Total
estazolam	0	0	2	0	0	0	1	3
flurazepam	0	0	4	3	1	1	0	9
temazepam	5	18	326	188	129	215	98	979
triazolam	17	1	1	0	1	1	0	21

NOTE: Results include all beneficiaries filling prescriptions in 2016. Beneficiaries may have started therapy before January 2016 and may have started therapy just prior to the July 2016 end data for inclusion in the analyses.

Utilization patterns thus far for 2016 indicate that the monthly and annual quantity limits implemented for triazolam have definitely been of impact in limiting use to less than 10 days as indicated in the labeling. Although the labeling for temazepam is similar, utilization patterns indicate that long-term use of this product is occurring.

CONCLUSIONS AND RECOMMENDATIONS

The results indicate that the quantity limits recommended by the DUR Board last year for triazolam have been very effective. They also indicate that similar quantity limits criteria are needed for temazepam to assure appropriate use based on current labeling. Adding limits for temazepam would also make the UPDL criteria consistent for these two products that have similar labeling.

Based on these results, the following recommendation is made for DUR Board consideration:

- DOM add the following clinical edits to assure more appropriate use of temazepam and to make the criteria consistent with those for triazolam:
    a. Quantity limit of 10-day supply per month
    b. Cumulative quantity limit of 60 days within a 365-day period

UPDATE ON CONCOMITANT USE OF BENZODIAZEPINES AND OPIOIDS

BACKGROUND

The Centers for Disease Control (CDC) Guidelines for Prescribing Opioids for Chronic Pain[1] were reviewed at the April 2016 DUR Board meeting. One of the CDC guideline recommendations was that *providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible.* At this meeting, the DUR Board recommended the following actions be taken by the Division of Medicaid (DOM):

a. Concomitant use of opioids and benzodiazepines should require a manual prior authorization (PA).
b. MS-DUR should provide an educational mailing to providers prescribing concurrent use of benzodiazepines and opioids regarding the increased safety risks and highlight the CDC recommendation to avoid concomitant use.

On August 31, 2016, the Food and Drug Administration (FDA) announced that after extensive review of the latest scientific evidence, class-wide changes to drug labeling are required. These changes include the new Boxed Warnings and revisions to the Warnings and Precautions, Drug Interactions, and Patient Counseling information sections of the labeling.[2] This information should help inform health care providers and patients of the serious risks associated with the combined use of certain opioid medications and benzodiazepines.

> WARNING: RISKS FROM CONCOMITANT USE WITH OPIOIDS
>
> Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death *[see Warnings and Precautions (5.1), Drug Interactions (7.X)]*.
>
> - Reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate.
> - Limit dosages and durations to the minimum required.
> - Follow patients for signs and symptoms of respiratory depression and sedation.

DOM is in the process of implementing an electronic PA edit to prevent concomitant use of these products without a manual PA. This report provides an update on current concomitant use of benzodiazepines and opioids in the Mississippi Medicaid population. These results will serve as a benchmark for evaluating the impact of implementing the two recommendations above.

METHODS

A retrospective analysis was conducted using DOM's pharmacy claims for all programs (fee-for-service (FFS) and coordinated care organizations (CCOs)) for the period January 1 ,2016 through July 31, 2016. All claims for benzodiazepines or opioids were identified. Beneficiaries were classified as on therapy for each product for the periods defined by each date of a prescription fill plus the days supply indicated on

[1] CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016.
http://www.cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1er-ebook.pdf
[2] FDA New Release, August 31, 2016.
http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm518697.htm

the prescription claim. Beneficiaries were considered to be taking both medications at the same time if their days of coverage for benzodiazepines and opioids overlapped.

RESULTS

As shown in Table 1, 11,884 beneficiaries filled prescriptions for opioids and benzodiazepines during this period.

- Of these beneficiaries, 9,781 (10.8%) were classified as taking both medications concomitantly.

Table 1: Number of Beneficiaries Filling Opioid and Benzodiazepine Prescriptions
(January - July, 2016 -- FFS and CCOs)

		Filled Benzodiazepine Rx	
		No	Yes
Filled Opioid Rx	No	0	7,330 (8.1%)
	Yes	71,370 (78.8%)	11,884 (13.1%)
		Concomitant Use	9,781 (10.8%)

The characteristics of beneficiaries with concomitant use of benzodiazepines and opioids are shown in Table 2.

- Almost all of these beneficiaries were ages 18 – 64 years and were not in long-term care facilities.
- More than two-thirds of these beneficiaries were female.
- More than half of beneficiaries with concomitant use were being treated with both benzodiazepines and opioids for more than 31 days.

Table 2: Characteristics of Beneficiaries With Concomitant Use of Benzodiazepine and Opioid
(January - July, 2016 -- FFS and CCOs)

		Beneficiaries With Concomitant Use of Benzodiazepine and Opioid	
		Number	Percent
Total unique beneficiaries		9,781	100.0%
Age*	Missing	3	0.0%
	5 or less	32	0.3%
	6 - 11	57	0.6%
	12 - 17	130	1.3%
	18 - 44	4,783	48.9%
	45 - 64	4,712	48.2%
	65+	64	0.7%
Pharmacy Coverage Plan	100 - Regular Adults	9,234	94.4%
	200 - Long Term Care	210	2.2%
	400 - EPSDT (children)	317	3.2%
	901 - Dual - LTC Facility	19	0.2%
	700 - K-Baby	1	0.0%
Gender	Female	7,488	76.6%
	Male	2,290	23.4%
Number of Days on Continous Benzodiazepine Therapy**	1 - 7 days	1,714	17.5%
	8 - 15 days	1,068	10.9%
	16 - 31 days	1,762	18.0%
	32 - 62 days	1,513	15.5%
	63-93 days	1,140	11.7%
	94 - 186 days	2,215	22.6%
	187 or more days	369	3.8%

** Age at end of July, 2016.*
*** Continous therapy was calcuated as date of first fill to date of last fill plus days supply for last fill, allowing for a 15 day refill gap.*

Concomitant use of two products involves two prescriptions that may not always be written by the same prescriber. The prescriber of the second product has the best opportunity to detect and avoid concomitant use, due to the availability of patient-specific medication use information when accessing the Mississippi Prescription Drug Monitoring Program (MS PMP). Table 3 denotes the provider types associated with the second product prescribed resulting in concomitant use of benzodiazepines and opioids, as well as the number of beneficiaries and the number of discrete concomitant events associated with each provider type.

Table 3: Type of Prescribers for Second Prescriptions Resulting In Discrete Events* of Benzodiazepine and Opioid Use

(January - July, 2016 -- FFS and CCOs)

Provider Type	Number of Providers	Distinct Beneficiaries		Total Discrete Concomitant Events*	Last Drug Filled for Discrete Events	
		Average Per Provider	Total		Benzo	Opioid
DDO-Dentist	192	2.35	452	485	248	237
HOSP-Psych	1	8.00	8	11	11	0
MD-Addiction	5	2.50	18	22	17	5
MD-Anesth	20	4.80	96	125	60	65
MD-Card	32	2.78	89	149	138	11
MD-EM	174	3.24	563	766	575	191
MD-FP/GP	498	10.06	4,918	8,156	7,358	798
MD-Gastro	15	5.07	76	120	104	16
MD-Hem/Onc	59	3.44	203	354	288	66
MD-Hospit	27	4.81	130	220	198	22
MD-ID	4	1.00	4	5	3	2
MD-IM	240	7.02	1,684	2,808	2,559	249
MD-Nephr	10	3.30	33	55	49	6
MD-Neur	70	7.06	494	795	656	139
MD-OB/GYN	102	2.95	301	454	379	75
MD-Ortho	71	2.24	159	180	81	99
MD-Pain	41	9.29	381	488	229	259
MD-Ped	55	3.84	211	324	281	43
MD-Psych	99	10.82	1,071	1,746	1,725	21
MD-Rad	10	2.20	22	31	24	7
MD-Rheum	7	2.29	16	23	20	3
MD-Sleep	5	1.40	7	12	12	0
MD-Surg	74	1.58	117	153	92	61
MD-Urol	16	2.25	36	51	33	18
NP	657	4.67	3,495	5,303	4,377	926
NP-Mental	61	13.20	805	1,323	1,323	0
Other	215	4.11	744	1,292	1,074	218
PA	45	5.87	315	487	416	71

** Discrete events were identified as each unique event of concomitant use involving the same prescribers and drugs.*

Discrete events were identified as each unique period of concomitant use involving the same prescribers and drug products. A total of 26,099 discrete events of concomitant use were identified.
Table 4 shows the drug combinations for the discrete concomitant events that occurred during this time period. Combinations of acetaminophen-hydrocodone with various benzodiazepines were the most common; with acetaminophen-alprazolam accounting for almost one-third of distinct events (31%).

Table 4: Drug Combinations Occurring With Discrete Concomitant Events of Benzodiazepine and Opioid Use
(January - July 2016 -- FFS and CCOs)

Drug Combination	Number of Events	Drug Combination	Number of Events
hydrocodone or hydrocodone-ibuprofen / alprazolam	9	acetaminophen-tramadol / alprazolam	71
hydrocodone or hydrocodone-ibuprofen / clonazepam	4	acetaminophen-tramadol / lorazepam	20
hydrocodone-ibuprofen / lorazepam	1	acetaminophen-tramadol / chlordiazepoxide	1
hydromorphone / alprazolam	89	acetaminophen-tramadol / clonazepam	31
hydromorphone / lorazepam	24	acetaminophen-tramadol / diazepam	17
hydromorphone / clonazepam	42	acetaminophen-tramadol / temazepam	6
hydromorphone / clorazepate	1	acetaminophen-tramadol / triazolam	1
hydromorphone / diazepam	37	acetaminophen/butalbital/caffeine/codeine / alprazolam	4
hydromorphone / temazepam	7	acetaminophen/butalbital/caffeine/codeine / clonazepam	6
acetaminophen-hydrocodone / alprazolam	7,996	acetaminophen/butalbital/caffeine/codeine / diazepam	3
acetaminophen-hydrocodone / lorazepam	1,486	acetaminophen/caffeine/dihydrocodeine / alprazolam	2
acetaminophen-hydrocodone / chlordiazepoxide	27	acetaminophen/caffeine/dihydrocodeine / clonazepam	3
acetaminophen-hydrocodone / clobazam	15	acetaminophen/caffeine/dihydrocodeine / clorazepate	2
acetaminophen-hydrocodone / clonazepam	3,826	acetaminophen/caffeine/dihydrocodeine / temazepam	1
acetaminophen-hydrocodone / clorazepate	122	buprenorphine / alprazolam	89
acetaminophen-hydrocodone / diazepam	1,858	buprenorphine / lorazepam	13
acetaminophen-hydrocodone / flurazepam	4	buprenorphine / chlordiazepoxide	1
acetaminophen-hydrocodone / oxazepam	4	buprenorphine / clobazam	1
acetaminophen-hydrocodone / temazepam	617	buprenorphine / clonazepam	56
acetaminophen-hydrocodone / triazolam	3	buprenorphine / clorazepate	1
acetaminophen-codeine / alprazolam	480	buprenorphine / diazepam	15
acetaminophen-codeine / lorazepam	85	buprenorphine / temazepam	2
acetaminophen-codeine / chlordiazepoxide	5	buprenorphine-naloxone / alprazolam	220
acetaminophen-codeine / clobazam	2	buprenorphine-naloxone / lorazepam	43
acetaminophen-codeine / clonazepam	252	buprenorphine-naloxone / clobazam	2
acetaminophen-codeine / clorazepate	9	buprenorphine-naloxone / clonazepam	238
acetaminophen-codeine / diazepam	112	buprenorphine-naloxone / clorazepate	3
acetaminophen-codeine / temazepam	40	buprenorphine-naloxone / diazepam	40
acetaminophen-oxycodone / alprazolam	1,550	buprenorphine-naloxone / temazepam	14
acetaminophen-oxycodone / lorazepam	295	butorphanol / alprazolam	2
acetaminophen-oxycodone / chlordiazepoxide	6	butorphanol / lorazepam	3
acetaminophen-oxycodone / clobazam	2	butorphanol / clonazepam	1
acetaminophen-oxycodone / clonazepam	774	fentanyl / alprazolam	260
acetaminophen-oxycodone / clorazepate	25	fentanyl / lorazepam	68
acetaminophen-oxycodone / diazepam	392	fentanyl / clonazepam	80
acetaminophen-oxycodone / oxazepam	2	fentanyl / clorazepate	3
acetaminophen-oxycodone / temazepam	145	fentanyl / diazepam	42
		fentanyl / oxazepam	2
		fentanyl / temazepam	18

Table 4: Drug Combinations Occurring With Discrete Concomitant Events of Benzodiazepine and Opioid Use *(Continued)* *(January - July 2016 -- FFS and CCOs)*			
Drug Combination	**Number of Events**	**Drug Combination**	**Number of Events**
meperidine / alprazolam	25	oxycodone / alprazolam	537
meperidine / lorazepam	4	oxycodone / lorazepam	100
meperidine / clonazepam	2	oxycodone / chlordiazepoxide	3
meperidine / clorazepate	1	oxycodone / clobazam	2
meperidine / diazepam	12	oxycodone / clonazepam	205
meperidine / temazepam	4	oxycodone / clorazepate	9
methadone / alprazolam	26	oxycodone / diazepam	109
methadone / lorazepam	2	oxycodone / temazepam	31
methadone / clobazam	3	oxymorphone / alprazolam	23
methadone / clonazepam	21	oxymorphone / lorazepam	7
methadone / diazepam	8	oxymorphone / clonazepam	19
morphine / alprazolam	314	oxymorphone / diazepam	13
morphine / lorazepam	70	tapentadol / alprazolam	4
morphine / chlordiazepoxide	1	tapentadol / clonazepam	3
morphine / clonazepam	111	tapentadol / diazepam	1
morphine / clorazepate	3	tapentadol / temazepam	2
morphine / diazepam	59	tramadol / alprazolam	1,282
morphine / temazepam	25	tramadol / lorazepam	299
morphine-naltrexone / alprazolam	44	tramadol / chlordiazepoxide	8
morphine-naltrexone / lorazepam	4	tramadol / clobazam	1
morphine-naltrexone / clonazepam	13	tramadol / clonazepam	645
morphine-naltrexone / clorazepate	3	tramadol / clorazepate	26
morphine-naltrexone / diazepam	8	tramadol / diazepam	184
morphine-naltrexone / temazepam	4	tramadol / oxazepam	2
naloxone-pentazocine / alprazolam	1	tramadol / temazepam	83

RECOMMENDATIONS AND BOARD ACTION

The information in this report is presented for informational purposes only and will serve as a baseline data reference for evaluating the impact of the electronic PA edit and an educational initiative.

No additional DUR Board action is requested at this time.

BUPRENORPHINE/NALOXONE THERAPY DOM CLINICAL GUIDELINES AND RECOMMENDED CHANGES

BACKGROUND

In September 2012, the Division of Medicaid (DOM) implemented criteria through electronic prior authorization (PA) and the pharmacy point-of-sale (POS) systems for managing use of buprenorphine/naloxone (Suboxone®) and buprenorphine (Subutex®) for the treatment of opioid dependence. The criteria were developed after a thorough review of other state Medicaid and commercial payer guidelines and in consultation with licensed prescribers of buprenorphine/naloxone and an addictionologist. DOM's goals were to alleviate the burden of a manual PA for prescribers by including the criteria in electronic PA and to provide adequate access to therapy while assuring appropriate use that would be cost-effective to the state. At the July, 2016 meeting of the DUR Board, MS-DUR reviewed the criteria and provided an analysis of buprenorphine/naloxone utilization patterns since the Sept 2012 implementation.

Previous information during DUR meetings highlighted:
1) major efforts directed by the Department of Health and Human Services (HHS)[1], the Centers for Disease Control (CDC)[2], the Food and Drug Administration (FDA)[3], and a multitude of professional associations and other health agencies to address the opioid abuse "epidemic" and focus attention to the increased need for drug abuse prevention and treatment efforts.
2) the increased use of medication assisted treatment (MAT) for opioid use disorders as an integral component of addressing opioid addiction. Existing evidence shows that MAT is under-utilized.

- MAT is the use of medications in combination with counseling and behavioral therapies to provide a comprehensive patient approach to the treatment of substance use disorders, including opioid use disorders.
- Currently, there are four MAT medications approved by the FDA for the treatment of opioid dependence: methadone, buprenorphine, buprenorphine/naloxone and naltrexone.
- Buprenorphine-based MAT is governed by the Controlled Substances Act (CSA), as amended by the Drug Addiction Treatment Act of 2000 (DATA 2000). Pursuant to DATA 2000 and recent amendments, practitioners may obtain a waiver to prescribe buprenorphine for treatment of opioid use disorder. Initially, they may treat up to 30 patients at a time. After one year they may file a request to treat up to 100 patients at a time and after another year they can request to treat up to 275 patients at a time. Only physicians may be authorized to prescribe buprenorphine for the treatment of opioid use disorder

Section 303 of the Comprehensive Addiction and Recovery Act (CARA), signed into law by President Obama in July 2016, made several changes to the law regarding office-based opioid addiction treatment with buprenorphine which expands prescribing privileges to nurse practitioners (NPs) and physician

[1] ASPE Issue Brief: Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths. https://aspe.hhs.gov/pdf-report/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths

[2] CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. http://www.cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1er-ebook.pdf

[3] Food and Drug Administration. Fact Sheet – FDA Opioids Action Plan. http://www.fda.gov/NewsEvents/Newsroom/FactSheets/ucm484714.htm

assistants (PAs) once they have received a waiver to prescribe buprenorphine. Specific details regarding training for NPs and PAs are currently underway.

With the increased focus on MAT and the need to treat opioid abuse more effectively, the restrictions often used to manage utilization of buprenorphine/naloxone treatment are being challenged. In March, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final ruling on how the Mental Health Parity and Addiction Equity Act of 2008 applied to Medicaid programs. In the ruling, CMS stated that no financial requirement or treatment limitation could be applied to mental health or substance use disorder related services that is more restrictive than the "predominant" financial requirement or treatment limitation of that type applied to "substantially all" medical/surgical benefits. Life-time limits for buprenorphine/naloxone therapy were cited as an example of unacceptable limitations.

During the July DUR Board Meeting, MS-DUR presented study results indicating the current maintenance dose level may be lower than providers are prescribing and that the 24-month life-time limit on therapy was potentially a barrier for only a small percentage of beneficiaries. This report provides additional information on the effect of cash prescriptions obtained from Mississippi's Prescription Drug Monitoring Program (MS PMP) on doses prescribed and the number of beneficiaries reaching the 24-month limit on therapy coverage.

METHODS

A retrospective analysis was conducted using DOM buprenorphine/naloxone and buprenorphine prescription claims data from the FFS and the two coordinated care organizations (CCO's), United Healthcare (UHC) and Magnolia (MAG) for the period January 1, 2015 through April 30, 2016. Information on buprenorphine and buprenorphine/naloxone prescriptions paid for with cash was extracted from the MS PMP's database and added to the data from Medicaid paid claims.

Maximum daily dosing limits are set for each month of therapy. Since DOM beneficiaries sometimes need multiple partial fills in a month and have compliance gaps (refill gaps < 60 days) between refills, the months of therapy is calculated based on cumulative days supply. For purposes of computing daily dosing each month on therapy, prescription fills were consolidated such that each individual fill represented the dosing for sequential 30-day increments.

RESULTS

Table 1: Step Therapy With Maximum Daily Doses for Initial Therapy Starts and Restarts

Current DOM treatment criteria require dose reduction over time with maximum daily doses established for each month of therapy (month 1, up to 24mg buprenorphine/6mg naloxone per day; months 2-5, up to 16mg/4mg per day; and remaining months, up to 8mg/2mg per day). It is important to note that the month of therapy is determined by cumulative days supply of therapy and not calendar months. This distinction addresses small refill gaps due to noncompliance and multiple partial fills during a calendar month. DOM's current treatment criteria limit the daily dose for maintenance therapy to a maximum of 8mg/2mg. According to the current prescribing information for Suboxone®, for maintenance treatment, the target dosage of Suboxone® sublingual film is usually 16mg/4mg as a single daily dose.

Table 1 shows the number of beneficiaries with an initial start or restart on buprenorphine/naloxone or buprenorphine therapy since January 2015 by daily dose levels each month. Due to the January 1, 2015 implementation of the Universal Preferred Drug List (UPDL) for DOM, this analysis only includes therapy beginning on or after January 1. Doses at or below the criteria maximums are shaded green.

As shown in Table 1, when cash payment prescriptions are included, almost all beneficiaries had maintenance daily doses below 16mg/4mg per day but over half of beneficiaries had daily doses that exceeded the current DOM limit of 8mg/2mg per day. These results indicate that providers usually prescribe within the recommended FDA approved dosage in the labeling. However, the prior authorization process is used by providers or cash payments are used by beneficiaries for prescriptions that exceed the current DOM maintenance dose criteria.

TABLE 1: Daily Dosing by Month on Therapy for New Starts and Restarts Beginnin After January 1, 2015

(FFS and CCOs with PMP Cash Claims Included)

DAILY DOSE - NEW STARTS After January 1, 2015									
Therapy Month*	<= 8 mg		>8 to <= 16 mg		>16 to <=24 mg		> 24 mg		Total Treated
1	97	12%	558	71%	123	16%	6	1%	784
2	60	11%	456	82%	36	6%	2	0%	554
3	45	10%	364	82%	31	7%	2	0%	442
4	44	13%	287	82%	19	5%	1	0%	351
5	35	12%	237	83%	11	4%	1	0%	284
6	55	24%	164	72%	10	4%	0	0%	229
7	62	34%	111	60%	11	6%	1	1%	185
8	50	33%	93	61%	9	6%	1	1%	153
9	38	30%	74	59%	11	9%	2	2%	125
10	35	34%	58	57%	8	8%	1	1%	102
11	29	36%	47	59%	3	4%	1	1%	80
12	21	38%	30	55%	3	5%	1	2%	55
13	17	41%	21	51%	3	7%	0	0%	41
14	11	39%	12	43%	5	18%	0	0%	28
15	2	13%	11	69%	3	19%	0	0%	16
16	2	25%	3	38%	3	38%	0	0%	8
17	1	33%	1	33%	1	33%	0	0%	3
18	1	50%	1	50%	0	0%	0	0%	2

DAILY DOSE - RESTARTS After January 1, 2015									
Therapy Month*	<= 8 mg		>8 to <= 16 mg		>16 to <=24 mg		> 24 mg		Total Treated
1	60	14%	308	74%	44	11%	3	1%	415
2	52	18%	211	73%	26	9%	2	1%	291
3	43	19%	167	73%	18	8%	1	0%	229
4	33	18%	136	75%	11	6%	2	1%	182
5	33	22%	107	73%	6	4%	1	1%	147
6	27	23%	80	69%	9	8%	0	0%	116
7	22	26%	58	67%	5	6%	1	1%	86
8	21	32%	40	62%	3	5%	1	2%	65
9	13	25%	34	65%	5	10%	0	0%	52
10	15	37%	23	56%	2	5%	1	2%	41
11	8	29%	18	64%	2	7%	0	0%	28
12	7	33%	14	67%	0	0%	0	0%	21
13	7	41%	10	59%	0	0%	0	0%	17
14	8	67%	4	33%	0	0%	0	0%	12
15	5	45%	5	45%	1	9%	0	0%	11
16	5	56%	3	33%	1	11%	0	0%	9
17	1	33%	1	33%	0	0%	1	33%	3
18	0	0%	0	0%	1	100%	0	0%	1
19	0	0%	0	0%	1	100%	0	0%	1
20	0	0%	0	0%	1	100%	0	0%	1
21	0	0%	0	0%	1	100%	0	0%	1
22	0	0%	0	0%	1	100%	0	0%	1
23	1	100%	0	0%	0	0%	0	0%	1

** Maximum daily dose limits are based on 30-day supply increments; therefore therapy month is caluculated as 30-day increments instead of calendar months.*

NOTE: Green shading indicates approved maximum daily dosing.

Table 2: Length of Coverage

Since the implementation of DOM's criteria, the cumulative number of months that beneficiaries have been on therapy with buprenorphine/naloxone or buprenorphine are represented in Table 2. The number and percentage of beneficiaries remaining on therapy for longer than 24 months increased slightly when cash paid prescriptions were included in the analysis. This indicates that cash paid prescriptions are being used in lieu of prior authorization requests for some beneficiaries to continue treatment.

TABLE 2: Number and Percentage of Beneficiaries by Total Cumulative Months on Therapy
(September 1, 2012 - April 30, 2016)

Total Cummulative Months* on Therapy	Medicaid Paid Claims Only		Medicaid Paid Claims Plus PMP Cash Claims	
6 months or less	1,267	51.5%	1232	50.1%
>6 months to 12 months	552	22.5%	541	22.0%
>12 months to 18 months	294	12.0%	311	12.6%
>18 months to 24 months	146	5.9%	143	5.8%
>24 months to 30 months	92	3.7%	100	4.1%
>30 months	107	4.4%	134	5.4%

** Maximum daily dose limits are based on 30-day supply increments; therefore therapy month is calculated as 30-day supply increments instead of calendar months.*

BOARD ACTION REQUESTED

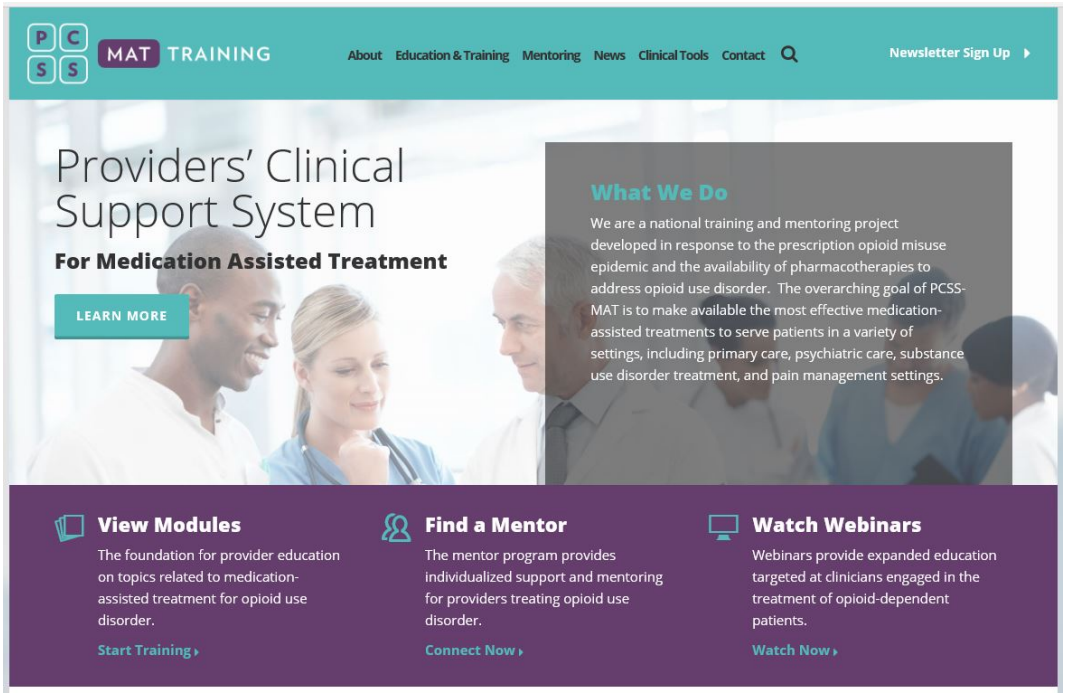
In light of the national initiatives to have MAT accessible and to ensure that DOM's clinical criteria is compliant with the Mental Health Parity and Addiction Equity Act of 2008, the DUR Board should consider the below recommendations.

Recommendations:
The DOM criteria for use of buprenorphine/naloxone and buprenorphine in the treatment of opioid dependence should be modified as follows:

a. **Appropriate Diagnosis** – unchanged
b. **Length of Coverage** – the 24-month maximum length of coverage and limits on restarts should be removed
c. **Step Therapy With Maximum Daily Doses** – change to:
   - Induction and stabilization phase – maximum daily dose of 24 mg/day for up to 2 months
   - Maintenance phase -- maximum daily dose of 16 mg/day
d. **Opioid Use Restriction** – unchanged

FREE PROVIDER TRAINING AND SUPPORT MATERIALS
FOR BECOMING CERTIFIED FOR MAT AND FOR TREATING OPIOID DEPENDENCE

PCSS-MAT.ORG



PCSS-O.ORG