

Alaska Medicaid DUR Committee Meeting Minutes

Alaska Medical Assistance DUR Committee Meeting

Friday, April 20, 2018

Frontier Building, 3601 C Street; Room 890/896

1:00pm

Attendees:

Drug Utilization Review Committee

Members Present	Non Members Present
Erin Narus (DHSS)	Elaine Edwards Magellan
Chuck Semling	Umang Patel Magellan
Jenna Heistand	Janelle Solbos
Bob Carlson	
Barb Piromalli	
Ryan Ruggles	

Review of Minutes

Review of Agenda

Prospective DUR Review/Clinical topics

New Prior Authorizations, Quantity Limits, Edits:

- Vitamin D Supplementation- Pregnant Women, infants
Open discussion. Erin Narus introduced need for Vitamin D supplementation specific to Alaska residents. It was suggested to implement basic criteria that is highly supported as medically necessary for infants and pregnancy. Alaska members can benefit with basic supplementation for pregnant patients and infants for age up to one year for Vitamin D oral drops (Drisdol, Baby drops 400 IU). A Submission clarification code can be used at point of sale to override for pregnant patients to decrease barriers to care in supplementation. An age edit can be instituted for infants to allow claims for patients less than 1 year to decrease occurrence of Ricketts. The Northern Latitude children are a concern. Motion given to approve by Barb Piromalli to include and seconded by Ryan Ruggles. Jenna Heistand and Bob Carlson in favor.
- Stimulants and Quantity Limit Open Discussion- This is a standard of care to consider. Erin Narus provided insight from a letter from CDC or WA State guideline was quoted. Bob Carlson said this is one item linked to early death. Providers fall for the demands. Ryan Ruggles stated it is a widespread problem. Barb Piromalli stated bigger practices don't see multiple medications. A letter to providers can serve as a catch to persuade providers to change their prescribing practice. Jenna Heistand mentioned patients are screening positive for medications and many patients are on ADHD meds at 55 years. Ryan Ruggles mentioned many patients have situational ADHD. Erin Narus expressed a high level of concern for opioid substance misuse who have dual diagnoses of ADHD and opioid dependence and proposed a prior authorization on ODT benzodiazepine use. Also the diagnosis of narcolepsy is often misread due to high dose

benzodiazepines with GAD diagnosis. Jenna Heistand recommended limiting IR stimulant use. With bipolar disorder, PTSD, and GAD patients often rarely have all the problems they are being medicated for. Topics mentioned of concern were poly-pharmacy, types of disorders being treated, insomnia meds with ADHD meds, dual diagnoses, letters to prescribers with patients on multiple uppers and downers, reconciliation piece and use of PDMP, need for referral to specialty care, barriers to care due to long months of wait times to see psych. providers, remote areas have limited access to specialty providers, need to develop treatment plans for improving the care given by available providers who have less expertise, educate with patient handouts, educate via guidelines available online with treatment algorithms. The committee discussed providers should take ownership. Peer-to-Peer guidance can be a solution. University of Washington has guidance available online and has a specialty line. Case presentations can be shown and heavy hitters using targeted medications can be identified for program signups.

- Opioids- Oxycodone solution, dental opioids, age specific. Open discussion occurred regarding addressing appropriate use edits to avoid and decrease probability of diversion with stimulants, opioids, benzodiazepines, carisoprodol (Soma), gabapentin with current opioid usage. Discussion was proposed that this committee consider reasonable, measurable and actionable restrictions on opioid prescriptions to minimize first opioid exposure and use. Setting adjudication rules for dental pain management to limit opioid prescriptions to less than or equal to 3 days was proposed. Also providing access to longer treatment therapy can be made through a prior authorization request to exceed quantity limits and number of days. The concept will require additional provider outreach. Utilization shows many never get prescribed opioids, and there was a balanced mixture of

NSAIDS vs opioids. Regarding CNS analgesics there was a small group of providers to reach out to who have no NSAIDS. Education of non-opioid drug therapy coverage is needed.

- Medication Assisted Therapy: Opioid Buprenorphine MAT Treatment Model

Currently AK Medicaid has no PA for downward taper. Higher barriers on other issues. Goal is to incentivize providers who are doing it right.

Comorbid conditions often apply to a patient's history. To encourage less utilization of opioids the ADA, CDC, other joint webinars online, and from peer to peer assistance the following expectations have been recommended or suggested as a requirement: The committee recommended to move forward with edits as proposed in discussion.

- PCSK9 Inhibitor presentation given by Janelle Solbos, Pharm D candidate 2020. The student outlined hyperlipidemia in US, current guidelines, studies compared to current standards of therapy and overall review. Summary and discussion after presentation:

ACC/AHA 2013 guidelines regarded 4 statin benefit groups with recommendations that focus on moderate and high intensity statin therapy. Goal is to achieve a specific percentage reduction in LDL-C. LDL-C is only measured to assess if patient responding to treatment and adherence — no LDL-C targets. No recommendations for non-statin therapy. Janelle discussed the FOURIER study and Odyssey study and review with main purpose was to compare safety and efficacy of alirocumab vs. placebo in patients with acute coronary syndrome (ACS) on intense or maximum tolerated statin therapy. Study inclusion criteria was same for both studies with age 40 y/o, 1-12 months since ACS event (acute MI or unstable angina), high-intensity statin therapy, maximum tolerated high-intensity statin, or documented intolerance to statins), cholesterol levels. Primary outcome: MSCE for alirocumab 9.5% vs placebo 11.1% (NNT=62.5) with HR (95% CI 0.78-0.93) P = 0.0003

Cost of therapy for one month: Repatha 420 mg/3.5 mL PUSHTRONX q month = \$333.09, Repatha 140 mg/mL SURECLICK q 2 weeks (2 x \$539.27) = \$1078.55, Praluent 150mg/mL PEN q 2 weeks (2 x \$542.8500) = \$1085.70 — maximum Dose, Praluent 75mg/mL PEN q 2 weeks (2 x \$543.111083) = \$1086.22 — initial dose

Discussion: At what point do you say someone has had a sufficient trial of statins? Bob Carlson stated monoclonal antibody drugs stop working after 3 to 4 yrs. What are the long-term issues with the drugs? At what dose do you decide to get to? Issue of adherence to therapy and measuring adherence is difficult. The committee proposed a failure of 2 high intensity statins. If 2 statin trials are required would there be an additional step? At what point are we just delaying the inevitable? What is the maximum dose? Committee members discussed Zetia additionally with a high potent statin due to max doses already achieved. Zetia works independently for MOA.

- Dental analgesia, clinical criteria and dosing: Clinically appropriate dental dosing discussion. Erin Narus and Chuck Semling will be speaking to dental association with a focus on pediatrics. In particular it is recommended and necessary to look at additional pain treatment strategies in many procedures including dental procedures, surgeries, and tonsillectomies to minimize use of opioids in pediatric populations. It is a critical opportunity for dental prescribers to talk about and change the conversation to improve outcome to decrease the opioid utilization.

Adjournment

4:40pm April 20th, 2018.