HFS
Illinois Department of
Healthcare and Family Services

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Illinois Drug Utilization Review
Advisory Board Meeting Minutes
October 31, 2024

I. Call to order, Roll call

A. Call to order
   1. Meeting conducted via Webex webinar format.
   2. The meeting was recorded in accordance with the Open Meetings Act. Guests wishing to speak during public comments were requested to type name and affiliation in the Webex Chat. Phone-in attendees were instructed to email Jen DeWitt with full name, title, and affiliation.
   3. Dr. Stevens called the meeting to order at 8:31 am.

B. Roll call
   1. Roll call was taken, and a quorum was established. Present: Drs. Stevens, Schriever, Aziz, Nikocevic, Sreedhar, Wheat. Not present: Dr. Ahluwalia

II. Approval of agenda and conflict of interest declaration

A. Motion to approve October 31, 2024 meeting agenda with no changes or additions. Motion to approve made by Dr. Nikocevic. Seconded by Dr. Aziz.

B. No DUR Advisory Board members had conflicts of interest pertinent to the agenda. Dr. Stevens reminded DUR Advisory Board members to recuse themselves from discussion if conflicts of interest are present and to provide an updated *Conflict of Interest* form if new conflicts arise.

C. Vote: In favor- 6; Against- 0; Abstentions- 0. Motion passes. October 31, 2024 agenda approved.

III. Approval of August 8, 2024 DUR Advisory Board meeting minutes

A. Motion to approve August 8, 2024 meeting minutes with no changes or additions. Motion to approve made by Dr. Nikocevic. Seconded by Dr. Aziz.

B. Vote: In favor- 6; Against- 0; Abstentions 0. Motion passes. August 8, 2024 meeting minutes approved.

IV. Approval of recorded meeting record destruction 18 months and older.

A. Motion to destroy recorded meeting records 18 months old (April 2023) and older made by Dr. Wheat. Seconded by Dr. Aziz.

B. Vote: In favor- 6; Against- 0; Abstentions- 0. Motion passes. Meeting recordings 18 months and older will be destroyed.

V. Board Updates – Claudia Colombo, PharmD

A. DUR Advisory Board Bylaws were approved by Healthcare & Family Services (HFS) Director Elizabeth Whitehorn on October 21, 2024. The approved Bylaws will be added to the HFS DUR Advisory Board website.

B. Director Whitehorn also approved 3 additional pharmacist candidates for DUR Advisory Board membership. Their terms will begin in January 2025.
   1. Chad Kodiak, PharmD

2. Priti Shah, PharmD
3. Stefanie Toomey, PharmD

C. 2025 Chairperson and Vice-Chairperson Nominations
   1. Discussion
      a. Dr. Sreedhar nominated herself for chairperson. Seconded by Dr. Nikocevic.
      b. Vote: In favor- 6; Against- 0; Abstentions 0. Motion passes. Dr. Sreedhar will be chairperson for 2025.
      c. Dr. Sreedhar nominated Dr. Nikocevic for vice-chairperson. Seconded by Dr. Aziz.
      d. Vote: In favor- 6; Against- 0; Abstentions- 0. Motion passes. Dr. Nikocevic will be vice-chairperson for 2025.

D. DUR Advisory Board member OneNet annual training modules
   1. Due date for modules: December 31, 2024.
   2. Claudia Colombo will send out an email to Board members with information and the link to the OneNet training website.

VI. Retrospective DUR

A. Clonazepam and concomitant opioid use – Christina Petrykiw, PharmD, CDCES
   1. At the August 8, 2024 meeting, the Board requested an update of concomitant opioid-benzodiazepine utilization that incorporated clonazepam to help determine whether clonazepam should be added to the current opioid-benzodiazepine edit. Clonazepam is categorized as a seizure medication and is not in the Medi-Span benzodiazepine category on which the current opioid-benzodiazepine edit is formulated. A review of diagnoses for participants filling clonazepam concomitantly with opioids was also requested.
   2. Recommendations/requirements for concomitant opioid therapy noted.
      a. FDA drug safety communication
      b. Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Participants and Communities Act (SUPPORT Act)
   3. Utilization for Fee-for-Service (FFS)
      a. Time periods compared: pre-edit (9/1/2019 – 8/31/2020) and the most recent state fiscal year post-edit (7/1/2023 – 6/30/2024).
      b. Review of concomitant opioid-benzodiazepine (including clonazepam therapy):
         i. At least 55% fewer participants are filling concomitant opioid-benzodiazepine therapy including clonazepam, during the post-edit period.
         ii. Once clonazepam is added to the claims reviewed, the top 3 benzodiazepines pre- and post-edit by claim count are alprazolam, clonazepam, and lorazepam.
         iii. After addition of clonazepam, there was no change in the top 3 concomitant opioids in the pre- and post-edit periods.
         iv. Percent of opioid claims at greater than 50 morphine milligram equivalents (MME) decreased when concomitant clonazepam-treated claims were added.
         v. Patterns of concomitant therapy utilization were reviewed in participants filling either medication chronically (3 months or more).
      c. Diagnoses in participants filling concomitant clonazepam and opioids were reviewed. The look-back period was 3 years (1/1/2021 through 6/30/2024). Participants filled clonazepam one or more times.
         i. 32.7% of participants filling clonazepam had a seizure diagnosis.

ii. Several participants had multiple mental health diagnoses. Clonazepam is FDA-labeled for panic disorder and other benzodiazepines are used in the management of anxiety. Of participants filling concomitant opioid and clonazepam therapy, 65% had anxiety, 10% had post-traumatic stress disorder, and 7% had panic disorder.

iii. Participants filling concomitant clonazepam and opioid therapy also had other conditions that increase risk for opioid-overdose and respiratory or central nervous system depression: substance dependence/abuse, COPD/emphysema/bronchitis, altered mental status, sleep apnea, sleep disorders, history of poisoning due to opioids, non-opioids, benzodiazepines, or sedative-hypnotic-anxiolytic agents, suicidal ideation or attempts, self-harm, and repeated falls.

d. Discussion

i. The current drug-drug interaction edit for concomitant therapy cannot be limited to participants with anxiety only if clonazepam is added. Currently clonazepam has a pass-through edit that facilitates no prior authorization for clonazepam if the patient has a seizure diagnosis in the Medicaid medical claims data warehouse. Clonazepam was not included in the drug-drug interaction benzodiazepine-opioid edit since clonazepam is in a different drug category (seizure medications) rather than in the benzodiazepine classification. Since clonazepam is in a different drug category, it is also not included in the benzodiazepine duplicate therapy edit. If clonazepam is added to the current benzodiazepine-opioid drug-drug interaction edit, prior authorization will be required.

ii. DUR Advisory Board members did not want to limit participants who are stabilized on clonazepam for seizures or panic attacks. Evidence-based guidelines note the efficacy of selective-serotonin-receptor-inhibitors (SSRIs) for anxiety. The SSRIs are also safer than benzodiazepines. Determining diagnosis for clonazepam and provider education regarding appropriate anxiety management would be helpful for participants filling clonazepam-opioid concomitant therapy.

iii. Periodic re-review will help determine need for additional safety edits. It would be helpful to know whether other states incorporate clonazepam into their benzodiazepine-opioid edits.

e. DUR Advisory Board recommendations

i. Motion made by Dr. Sreedhar for participants filling concomitant clonazepam-opioid therapy to target education to prescribers of clonazepam for anxiety. Seconded by Dr. Schriever.

ii. Vote: In favor- 6; Against- 0; Abstentions- 0. Motion passes.

VII. Prospective DUR

A. Opioid prescribing and naloxone utilization – Maurice Shaw, PharmD

1. Illinois Controlled Substance Act was clarified as per request from the August meeting.

a. Currently, an offer of naloxone or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression is required. Naloxone is not required to be dispensed.

b. The recent legislation that would have made dispensing mandatory did not pass.

2. Data run and analysis.
    a. Participants who filled an opioid prescription from 7/1/2023 to 12/31/2023 were identified. Medication profiles were reviewed back two years to 7/1/2021 to determine how many participants that had a claim for an opioid also had a claim for an opioid reversal agent.
    b. FFS participants: 5.5% of participants had a naloxone claim.
    c. Managed care organization (MCO): 11.1% of participants had a naloxone claim.
3. Discussion
    a. The Board moved to:
        i. Educate prescribers on how to offer opioid reversal agents to participants via Academic Detailing and an online Zoom recording.
        ii. Approach commonly used medical informatics systems in Illinois (i.e., EPIC) to see if a naloxone alert can be triggered and hospital P&T committees to make sure the edit is implemented.
    b. Motion made by Dr. Nikocevic. Seconded by Dr. Sreedhar.
    c. Vote: In favor- 6; Against- 0; Abstentions- 0. Motion passes.

B. Concomitant H_2-antagonists and proton pump inhibitors (PPI) – Christina Petrykiw, CDCES
1. RetroDUR 300 reviews identified participants filling H2-antagonists concomitantly with PPI. The DUR Advisory Board had recommended a drug-drug interaction edit be put in place that would require prior authorization for concomitant use. The extent of concomitant utilization in the Illinois Medicaid population was evaluated to determine need for a prospective edit.
2. Recommendations for the use of H_2-antagonists or PPIs were reviewed:
    a. FDA-approved indications in package inserts for the Preferred Drug List medications (cimetidine, famotidine, nizatidine, lansoprazole, omeprazole, pantoprazole): concomitant use was not recommended in package inserts.
    b. Guidelines for the FDA-approved indications for H_2-antagonists and PPI: concomitant use is not recommended in evidence-based guidelines. Some guidelines note that concomitant use does not provide additional benefit and may decrease effectiveness of PPIs.
3. Utilization
    a. Time period of review: Calendar year 2023
    b. Overall, in Illinois Medicaid, over 15,000 unique participants received concomitant H_2-antagonist and PPI therapy in the same month.
    c. Utilization review revealed the following:
        i. Famotidine was the primary H_2-antagonist used (98.8% of all claims) in FFS and MCO Medicaid.
        ii. Omeprazole and pantoprazole were the main PPIs used across Illinois Medicaid (FFS and MCO) at 59% and 39% of claims respectively.
        iii. In FFS participants, overall duration of concomitant therapy ranged from 1 to 12 consecutive months.
            1. 75% of all FFS participants filled concomitant therapy for 1 month. Of these, 82% of participants filled concomitant therapy for 1 month only and 18% of participants filled for 1 month concomitantly along with additional months of monotherapy of one or both drug classes.
            2. About 25% of participants used concomitant therapy for 2 or more consecutive months. Additional months of monotherapy of one or both drug classes were filled in at least 50% of these participants.

3. Further review was conducted for participants filling concomitant therapy for 4 to 12 consecutive months. Five participants were no longer filling concomitant therapy in 2024 to date. Ten participants had multiple prescribers. Pertinent diagnoses present in the last 3 years included dysphagia, gastroesophageal reflux disease (GERD), gastrointestinal bleeds, gastritis/duodenitis with and without bleeding, esophageal or duodenal ulcers without bleeding, hematemesis, gastrostomy/colostomy/enterostomy. Several participants also had a tracheostomy or respiratory ventilator dependence, cerebral palsy, and two participants had blood disorders (von Willebrand disease and sickle cell trait). Many participants had diagnoses to support use of a H_2-antagonist or a PPI.

iv. Preferred Drug List status and age-based safety edits for the H_2-antagonists and PPI were reviewed. All preferred medications in these drug classes are subject to the Four Prescription Policy. Age edits are in place for lansoprazole (prior authorization (PA) for 11 years of age and older) as well as for omeprazole and oral pantoprazole (PA for 21 years of age and older). The FFS participants filling concomitant therapy for 4-12 months were between 2 and 19 years of age. Claims for lansoprazole orally disintegrating tablets (ODT) would have required prior authorization because by the time of refills the participants were older.

4. Discussion
    a. The DUR Advisory Board members noted that if there is no evidence to support concomitant use, then it should not be permitted beyond a 1-month transition between monotherapies.
5. DUR Advisory Board recommendations
    a. Motion made by Dr. Sreedhar to not permit concomitant use of an H_2-antagonist with a PPI beyond 1 month of therapy. Seconded by Dr. Aziz.
    b. Vote: In-favor- 6; Against- 0; Abstentions- 0. Motion passes.

VIII. Education

A. Vitamin D – Claudia Colombo, PharmD
    1. Waiting for authorization to release a Provider Notice with the updated vitamin D guideline.

IX. Quarterly Reports – Maurice Shaw, PharmD

A. Top 10 spend FFS drugs (2024Q2)
    1. Four new drugs have moved into the top 10 for spend due to prior authorization edits being turned off as a result of the Optum Rx/Change Healthcare cyberattack: Ozempic/Rybelsus (semaglutide), Gattex (teduglutide), Mounjaro (tirzepatide), and Eliquis (apixaban).
B. Dipeptidyl peptidase-4 (DPP-4) inhibitor follow-up
    1. The Board had previously asked why Januvia (sitagliptin) is consistently in the top 10 spend.
    2. Data was run for calendar year 2023 to determine Januvia utilization. Sixty percent of the claims for the DPP-4 inhibitors were for Januvia. DPP-4 inhibitors only accounted for approximately 8% of claims for antidiabetic medications (with a downward trend) and

accounted for approximately 8% of unique recipients taking an antidiabetic medication (with a downward trend).

3. Discussion: DPP-4 inhibitors
    i. Comparison of the time frame of however many months there was where there was no prior authorization compared to the previous 6 months where there was prior authorization.
    ii. Board decided no recommendations for PP-4 inhibitors for now unless the cost starts increasing. Recommend looking at data again next year.

C. Top 10 script count FFS- Prescription only (2024Q2): No changes from previous quarter.
D. Top 10 script count FFS- OTC only (2024Q2): No major changes from previous quarter.
E. Utilization of antihistamines and intranasal corticosteroids follow-up
    1. Board had previously requested utilization data for loratadine, cetirizine, and intranasal fluticasone due to loratadine's consistent presence in the top 10 OTC script count.
    2. Most of the utilization for the OTC loratadine is from our community integrated living arrangements (CILA) and supportive living facility (SLF) populations. It is likely easier for staff to administer oral antihistamines as opposed to intranasal corticosteroids. Staffing of these facilities also likely may influence this prescribing.
F. Glipizide utilization follow-up
    1. Board had previously requested utilization data for glipizide to see if utilization has been trending down.
    2. FFS, calendar year 2023: claims for glipizide were consistent from January 2023 (1,065 claims) to December 2023 (1,039 claims).
    3. MCO, calendar year 2023: claims for glipizide had a slight trend downward from January 2023 (9,779 claims) to December 2023 (8,179 claims).
    4. Discussion
        a. Since this data was from 2023, Board said they would like a more recent data run.
        b. No formal motions made, but Board would like further education for prescribers regarding appropriate medication use for diabetes via Academic Detailing. Bureau of Professional and Ancillary Services (BPAS) will further investigate who the top prescribers of glipizide are and the location of those prescribers so that UIC can perform provider outreach.
G. Disease-specific reports not presented at this meeting because data is currently not available due to the Optum Rx/Change Healthcare cyberattack.

X. Public Comments – No public comments were made.

XI. Announcements, Updates

A. New/Old Business – Claudia Colombo, PharmD
    1. Updated budesonide-formoterol inhaler quantity limits for FFS and MCO.
        a. Board's motion from the April 25, 2024 meeting was to discuss removing quantity limits from inhaled corticosteroid (ICS)-formoterol inhalers with the MCOs at the next quarterly IAMHP/HFS meeting. Quantity limits were discussed with the MCOs on September 10, 2024.
        b. Quantity limits for budesonide-formoterol inhaler quantity limits are now as follows: FFS- No quantity limits, Aetna- 1 inhaler per 20 days; BCBS and CountyCare- 3

inhalers per 30 days, Meridian- 3 inhalers per 30 days (previously 1 inhaler per 30 days), and Molina- 3 inhalers per 30 days (previously 2 inhalers per 30 days).

c. Another IAMHP/HFS meeting is scheduled for November 19, 2024, a discussion will be held again about quantity limits and aiming to get consistency across all of the MCOs.

B. Department update – Jose Jimenez, Bureau Chief
   1. No new updates.

C. Board Discussion
   1. Board discussed input they would like considered when HFS procures a new or updated pharmacy benefits management system.

XII. Adjournment

A. Next DUR Board meeting- Thursday, January 30, 2025, 8:30am – 10:30am

B. Motion made to adjourn the meeting at 10:14 am by Dr. Stevens, seconded by Dr. Sreedhar.
   1. Vote: In favor- 6; Against-0, Abstentions -0. Meeting adjourned.

Meeting Attendance

DUR Board Members
Erica Stevens, PharmD, BCGP, Chair
Christopher Schriever, PharmD, MS, AAHIVP, Vice-Chair
Ihab Aziz, MD, ABFM, FAAFP
Bedrija Nikocevic, PharmD, BCACP
Radhika Sreedhar, MD, MS, FACP
Santina Wheat, MD, MPH, FAAFP, AAHIVS

Staff/Panelists
Claudia Colombo, PharmD – UIC Springfield
Melissa Davis – BPAS
Jennifer DeWitt, BSPharm – UIC Springfield
Sheri Dolan, BSPharm – UIC Springfield
Thomas Dorn, PharmD – UIC
Heather Freeman – BPAS
Arvind Goyal, MD, MPH, MBA - Medical Director, HFS
Jose Jimenez – Bureau Chief, BPAS
Mary Moody, BSPharm – UIC
Christina Petrykiw, PharmD, CDCES – UIC
Maurice Shaw, PharmD – UIC Springfield

Guests/Attendees
Mark Baldridge
Davis Bedich
Patrick Boland
Kimbra Brooks
John Bullard
Dan Calloway
Kevin Hall
Janie Huff
Clemice Hurst
Doug Johnson
Greg Kitchens

Jeff Knappen
Chad Kodiak
Huzefa Master
Dani Mendez
Steve Patterson
Nichole Palusinski
Gary Parenteau
Kenneth Ring
Ryan Segroves
Priti Shah
Michele Shirley
Sam Sutton
Thomas Vayalil
Chase Williams
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