

## **Drug Utilization Review Board Meeting Summary**

**Wednesday, February 15, 2017**

The Drug Utilization Review (DUR) Board met on Wednesday, February 15, 2017, at 8:30 a.m. in Conference Room 013023213B-16, University of Illinois at Chicago College of Pharmacy, 833 S. Wood Street, Chicago, Illinois. 097790901115167959

DUR Board members in attendance: Rachel Caskey, MD; chairperson; Tim Lehan\*, BSPHarm; Anitha Nagelli, PharmD, M.Ed, Vice-chairperson; John E. Tulley, MD.

Illinois Department of Healthcare and Family Services (HFS) Representatives: Donna Clay BSPHarm, Prior Authorization, University of Illinois at Chicago (UIC); Sheri Dolan, BSPHarm\*, HFS Bureau of Professional and Ancillary Services (BPAS); Arvind K. Goyal\*, MD, Medical Director, Medical Programs, HFS; Mary Lynn Moody\*, BSPHarm, UIC; Christina Petrykiw, PharmD, CDE, UIC.

Interested parties: Dan Coleman, Merck; Chris Gillette, Pfizer; Mike Holmes, Sunovion Pharmaceuticals; Keith Huff, Novartis; Casey Johnson, Viiv; Michael LaFond, Abbvie; Sara Kinnebrew, Abbvie; Marcia Luchett, Genentech; Keith McCoy, Pfizer; Roberta Neuwirth, GSK; Ashley Polce, Abbvie; Aaron Shaw, Boehringer Ingelheim.

\*Attendance via teleconference

**Call to Order.** Rachel Caskey, MD, called the meeting to order on February 15, 2017 at 8:34 am.

**Agenda, conflict of interest review, and approval of September 21, 2016 meeting minutes.** Illinois DUR Board members had no changes to the February 15, 2017 meeting agenda or the September 21, 2016 minutes, except for the spelling of Eplclusa. Anitha Nagelli, PharmD, made a motion, seconded by Rachel Caskey, MD, and the DUR Board unanimously approved the September 21, 2016 minutes. Rachel Caskey, MD, requested DUR Board members to recuse themselves from discussion if a conflict of interest exists and to update their Conflict of Interest form if needed.

**HFS Bureau of Professional and Ancillary Services report.** Mary Lynn Moody, BSPHarm, mentioned that HFS is in the final stages of replacing the Illinois legacy Medicaid Management Information System (MMIS). The new web-based Pharmacy Benefits Management System (PBMS) is scheduled to launch March 27, 2017. Currently system testing is occurring to ensure functionality. Medical providers not enrolled with HFS will not have their prescriptions processed via Medicaid insurance at point of sale when the new system launches. All existing enrolled providers have been validated in the system. Currently HFS is reaching out to new providers to ensure they are validated. Prescribers may register to be active Medicaid providers via Impact at <https://www.illinois.gov/hfs/impact/>. Mary Lynn Moody, BSPHarm, also noted that HFS is expanding the DUR Board and if any physicians or pharmacists are interested in serving on the DUR Board, they should reach out to Mary Lynn Moody, BSPHarm, at [MLMoody@uic.edu](mailto:MLMoody@uic.edu) or to Mark Huston, Chief, BPAS. Anitha Nagelli, PharmD, asked whether the new system will send edit messages back to the pharmacy as occurs with the current MMIS. Mary Lynn Moody, BSPHarm, noted that edit communication regarding claims will continue in the new system.

**DUR Board Meeting schedule 2017.** Christina Petrykiw, PharmD, reviewed the schedule of meetings for the DUR Board for 2017. Anitha Nagelli, PharmD, made a motion to approve, seconded by Rachel Caskey, MD and the DUR Board unanimously approved the meeting schedule for 2017. The schedule is posted on the DUR Board Website (<https://www.illinois.gov/hfs/About/BoardsandCommissions/DUR>).

**DUR Annual Report FFY15.** Christina Petrykiw, PharmD, informed DUR Board members that the Medicaid DUR Annual Report, which reflects the federal fiscal year (October 1 through September 30<sup>th</sup> of the following year) was

### **2.15.17 Illinois Drug Utilization Review Board Meeting Summary**

submitted for FFY2015 by the deadline of September 30, 2016. The DUR annual reports are posted by the Centers for Medicare and Medicaid at <https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/annual-reports/index.html>. Data submitted for Table 1 that address top drug claims data were reviewed, specifically, top 10 prior authorization requests by drug name and drug class, top 5 claim denial reasons, and top 10 drug names by amount paid and by claim count. Many of the medications/drug classes have been discussed at DUR Board meetings. Dr. Goyal noted that several medications for the treatment of human immunodeficiency virus (HIV) infection are in the top 10 medications by amount paid. These medications may also be available through Illinois Department of Public Health (IDPH). Dr. Goyal asked whether cost savings can occur if participants receive medications through IDPH. Donna Clay, BSPharm, noted that HFS does not have access to information about participants' use of IDPH services. Dr. Goyal requested future removal of glucose test strips from the list, since they are more like a device rather than a drug. Christina Petrykiw, PharmD, noted that this will be done in the future, although test strips are an item under pharmacy services that received many requests which is why they had been included. Approval and denial data for the top 10 prior authorization requests by drug name and the main denial reasons were also presented. Dr. Goyal expressed appreciation for this topic presentation.

**Drug & Therapeutics Committee PDL changes 2016.** Christina Petrykiw, PharmD, notified DUR Board members about the 31 medications reviewed by the Drug & Therapeutics (D&T) Committee in 2016 at their quarterly meetings. Initially, newly marketed medications require prior authorization. A decision about including the medication on the Preferred Drug List (PDL) and/or requiring continued prior authorization is made when the medication is reviewed by the D&T Committee. Prior authorization may be required even if a medication is on the PDL if the medication requires additional monitoring for therapeutic success or patient safety. The D&T Committee recommendations and final HFS decisions are posted on the Committee on Drugs and Therapeutics Webpage at <https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/CommitteeonDrugsandTherapeutics.aspx>. Prior authorization criteria are developed by Prior Authorization staff in consultation with the Drug Information Group at UIC College of Pharmacy and the Prior Authorization Medical Directors. Criteria may be presented to the DUR Board throughout the year.

### **Prospective Drug Utilization Review**

**Codeine in pediatric patients.** Christina Petrykiw, PharmD, reviewed Drug Enforcement Agency (DEA) Schedule II and III prescription codeine-containing products used in the management of pain and Schedule V over-the-counter codeine-containing products used in the management of cough. Codeine is a prodrug that is partially metabolized by the hepatic cytochrome-p450- isoenzyme 2D6 (CYP2D6) to morphine. Morphine is further metabolized to glucuronide metabolites. Genetic differences in CYP2D6 lead to faster or more complete conversion of codeine to morphine (ultrarapid or extensive metabolizers) or no conversion to morphine at all (poor metabolizers). Approximately 77% to 92% of people may be extensive metabolizers. At least 2% of people overall can be ultrarapid metabolizers. There may be ethnic differences in ultrarapid metabolism, for example, up to 1% of Chinese, Hispanic, and Japanese persons, 1% to 10% of Caucasians, 3% of African Americans, and up to 28% of Arab, North African, or Ethiopian persons may be ultrametabolizers of codeine. This can result in suprathreshold effects and side effects. Checking metabolic rate is not commonly done in clinical practice, thus the only hint may be ethnicity. Hepatic enzyme systems are expected to mature by 12 years of age. Adverse effects that have been reported in children include neonatal death and fatal respiratory depression. A breast-fed infant died due to morphine toxicity from the mother who was an ultrametabolizer and was taking codeine. Fatal respiratory depression has occurred post-operatively in children undergoing tonsillectomy for obstructive sleep apnea. The timeline for toxicity varies from 1 to 2 days from start of codeine to just after one dose. The median time is 5 doses. Blood levels of codeine/morphine may be in the therapeutic range or increased when adverse effects occur. Contributing factors may be drug interactions. A Food and Drug Administration (FDA) review of respiratory depression due to codeine noted 64 events, including 24 deaths, 21 hospitalizations, and 16 life-threatening episodes. At least 25% of events were in children less than 2 years of age, 36% in those 2 to 5 years of age, 17% in children 6 to 11 years old, and 22% in teenagers. The most commonly implicated products were acetaminophen with codeine and codeine with promethazine with or without phenylephrine. Evaluation of Emergency Room visits also notes sedation and unusual sleepiness, mostly in teenagers, primarily due to acetaminophen with codeine. Current product labeling restricts codeine single-ingredient products and codeine with chlorpheniramine to patients 18 years of age and older and combination products with aspirin, caffeine, and dihydrocodeine to patients 12 years of age and older. Acetaminophen with codeine liquid is allowed in children 3 years of age and older. Codeine combinations with promethazine with or without phenylephrine may be used in patients 6 years of age and older. Most

### 2.15.17 Illinois Drug Utilization Review Board Meeting Summary

of the products are contraindicated for use in the management of post-operative pain. The FDA's Public Health Advisory in 2007 addressed the variability of codeine metabolism and risk of respiratory depression. The FDA's Drug Safety Communication in 2012 warned about death and respiratory depression after surgeries to treat obstructive sleep apnea, and a Black Box Warning in 2013 cautioned against use of codeine post-operatively in children. In 2013 and 2015 the European and Canadian agencies also incorporated warnings, contraindications, and maximum daily quantities for codeine products. In 2015 the FDA required a contraindication for codeine-containing cough-cold products in children less than 18 years of age due to the adverse effect of respiratory depression. The FDA recommends treating acute moderate pain with codeine in children over 12 years of age only if pain cannot be treated with acetaminophen or ibuprofen; not giving patients undergoing surgery for obstructive sleep apnea or breathing problems codeine products, and not using codeine products in ultra-rapid metabolizers or lactating women. When codeine-containing products are the only treatment option, the lowest effective dose for the shortest time period on an as-needed, rather than scheduled, basis should be used. No more than 6 doses per day should be administered. Additionally patients and parents should be educated regarding unusual sleepiness, confusion, or breathing changes. In patients experiencing these effects, codeine should be stopped and immediate medical attention received. Policies of the American Academy of Otolaryngology-Head and Neck Surgery, World Health Organization, American Academy of Pediatrics, and American College of Chest Physicians no longer recommend use of codeine in children for analgesic or anti-tussive effects. Retail pharmacy prescription trends demonstrate some decreases in the numbers of children of all ages who have received codeine-containing prescriptions. Codeine-containing product usage has also decreased 45% in HFS Fee-for-Service covered children less than 18 years of age. The predominant product used in the HFS population has been acetaminophen with codeine. Review of HFS claims for codeine products in children for calendar year 2016 found that almost 94% of codeine users were not children under the Department of Child and Family Services (DCFS). Potential alternatives for pain management in children include ibuprofen and acetaminophen (as long as hepatic function is monitored). If pain relief is insufficient, an acetaminophen with hydrocodone liquid formulation may be used in children 2 years of age and acetaminophen with oxycodone may be used in children 6 years of age and older. These products may have safety concerns as well. Hydrocodone is converted by CYP2D6 to the more potent hydromorphone and oxycodone undergoes metabolism by CYP3A4 and 2D6. The World Health Organization recommends morphine for moderate to severe pain. For cough, alternatives include benzonatate in children 10 years of age and older who can swallow capsules, cough syrup containing hydrocodone, OTC products containing dextromethorphan or menthol for children 2 years of age and older, or products with diphenhydramine in those 6 years of age and older. The DUR Board discussed whether to incorporate an age edit for codeine products. Dr. Tulley noted that there is limited justification for codeine use in children. Dr. Caskey did not feel there was a need for these products in children less than 18 years of age. Dr. Goyal noted codeine had been a potential product for post-operative analgesia in the past in select patients. He questioned the continued availability of the combinations of codeine, butalbital, acetaminophen/aspirin and caffeine as well as the codeine, aspirin, and carisoprodol product since better alternatives exist. Christina Petrykiw, PharmD, noted that continued HFS availability of these products would be an issue for the D&T Committee. The DUR Board can address the age edit. Both of these products carry contraindications for use in the treatment of post-operative pain in children. Dr. Tulley requested that previous prescribers of codeine-containing products in children receive an educational prescriber letter notifying them of the age edit and potential existing alternatives. Anitha Nagelli, PharmD, agreed for the need to educate providers. Sheri Dolan, BSPHarm, noted that the age edit would trigger a requirement for prior authorization so a request for codeine-containing product could be reviewed and approved if appropriate and safe for the patient. Rachel Caskey, MD made a motion, seconded by Dr. Tulley to make the age for codeine-containing products 18 years of age and older provided that prescribers are educated regarding this issue. The DUR Board unanimously approved the age edit with the education provision. Mary Lynn Moody, BSPHarm, noted that HFS will reach out to the Illinois Academy of Pediatrics to have them post the link to the educational letter on their site to help ensure more prescribers are reached.

**Fentanyl.** Christina Petrykiw, PharmD, provided an update regarding the fentanyl patch change to non-preferred status. In June 2016, the HFS D&T Committee recommended fentanyl patches be changed to non-preferred on the PDL. In July 2016, prescribers of 560 participants were notified about the change of fentanyl status via informational faxes and posting of the fentanyl notice in the education section of the Drug Utilization Review Webpage. Effective August 15, 2016 fentanyl patches became non-preferred. The current preferred long-acting opioids are extended-release morphine oral tablets and abuse-deterrent morphine capsules (Embeda). Temporary approvals were entered for current fentanyl patch users. Throughout fall 2016, the Medication Review and Academic Detailing pharmacists reviewed the medication profiles of the patients for whom temporary approvals had been entered. Over 111 patient-specific *Pain Management Program Letter of Medical Necessity for Long-Term Opioid Use* for participants not already

### 2.15.17 Illinois Drug Utilization Review Board Meeting Summary

enrolled in the pain management program were sent to prescribers. On an ongoing basis, prior authorization requests for fentanyl continue to be processed into the Pain Management Program. Of the pain management program forms returned since August 15, 2016, 120 have been approved and 74 were denied. Of the renewal pain management program forms returned, 17 were approved and 16 were denied. Some of the requests denied may be approved once additional information is provided. Overall between August 15, 2016 and February 9, 2017 a total of 1,591 prior authorization requests have been received for various strengths of fentanyl. About 55% of the requests were approved. Initial requests for fentanyl are denied and prescribers are educated about the current long-term narcotics that are preferred. It may take more than 6 months for prescribers to adapt to the non-preferred status of fentanyl. Dr. Goyal asked since initial approvals are for 3 months, could a patient receive a 3-month supply at one time. Tim Lehan, BSPHarm, noted that a pharmacy can only dispense a 1-month supply at a time.

**Diabetes medications.** Christina Petrykiw, PharmD, CDE, reviewed current recommendations for first line therapy for type 2 diabetes mellitus from the American Association of Diabetes (ADA), American Association of Clinical Endocrinologists, European Association for the Study of Diabetes, American College of Physicians, and International Diabetes Federation. All of the guidelines recommend metformin, if not contraindicated, and if tolerated, as the preferred initial pharmacologic agent for the treatment of type 2 diabetes. A retrospective, insurer patient-centered comparative effectiveness study noted that despite guideline recommendations, only approximately 58% of patients started metformin as their initial pharmacologic therapy for diabetes. Starting therapy with metformin decreased need to intensify therapy with time compared with sulfonylureas, thiazolidinediones, or DPP-4 inhibitors. Sulfonylureas caused hypoglycemia and an increase in cardiovascular events. (*JAMA Intern Med, 2014;174(2):1955-1962.*) A recent systematic review and meta-analysis found that clinical evidence supports benefit of using metformin as first-line therapy based on its effects on glycosylated hemoglobin (hemoglobin A1c), weight, and cardiovascular mortality. (*Ann Int Med, 2016 Jun 7; 164(11):740-51.*) The DUR Board discussed whether HFS should create a step therapy requirement for type 2 diabetes that would require metformin to be first-line therapy. Dr. Tulley noted that glycosylated hemoglobin levels (A1c) should be considered. A high A1c and symptoms would warrant insulin and those patients should not be required to start with metformin therapy. Similarly, if the patient is already taking insulin, they should not be required to stop and undergo a trial of metformin before continuing insulin (step-down therapy). Anitha Nagalli, PharmD, asked whether the information from the edit would go back to the pharmacy so that a frontline practitioner may be able to facilitate improvement of glycemic control. The HFS staff noted that edits would be transmitted to the pharmacy. The DUR Board requested more information about the potential impact of a metformin step-therapy edit on prior authorization staff and other stakeholders that would be required to justify therapy. The type of required documentation from medical prescribers should be considered. New HFS point-of-sale adjudication system capabilities to assist in a step therapy edit should be evaluated. Trial of metformin for the step therapy needs to be defined. For example, if the patient only tried the starting dose of metformin 500 mg three years ago, would that be a sufficient trial? Determining whether metformin could be added to current long-acting insulin therapy, i.e., Lantus, is another consideration. A requirement for prior authorization for a medication on the PDL would need to be approved by the D&T Committee.

### Retrospective Drug Utilization Review

**Attention Deficit Hyperactivity Disorder (ADHD) medications in children.** Christina Petrykiw, PharmD, reviewed the Washington state Medicaid ADHD medication limits based on age and dose. Exceeding these limits was a criteria used to identify which covered HFS children 5 to 8 years of age filling ADHD medications in 2016 would potentially need a peer-to-peer prescriber consultation. Only 1% of prescriptions filled for a 30-day supply of ADHD medications had doses exceeding the Washington dosing criteria for age. The ages of the individual children for whom doses were exceeded were as follows: 3% were 5 years of age, 10% were 6 years of age, 34% were 7 years of age and 58% were 8 years of age. Currently prior authorization approval is required for ADHD medications for children less than 6 years of age. Children for whom prior authorization is currently or was recently required do not seem to exceed recommended doses as much as older children. Mary Lynn Moody, BSPHarm, reviewed the dosing limits for specific age groups that will be used by the University of Illinois Department of Child and Adolescent Psychiatry DocAssist program. The guidelines are a modified version of the Washington criteria. If a requested medication is outside of the guidelines, the Prior Authorization Group can request a review by DocAssist. The purpose of the review is to ensure safe and effective prescribing and to educate clinical practitioners about appropriate treatment of ADHD. Higher doses may often be used and are ineffective because of misdiagnosis or concomitant diseases for which more appropriate therapy should be used. This will help ensure ADHD, not another condition, is being treated. The process will start for children 6 years of

### **2.15.17 Illinois Drug Utilization Review Board Meeting Summary**

age. Eventually the process will be expanded to more age groups with an aim to be available in areas without psychiatrists. Prior Authorization staff will continue to educate prescribers to use recommended age-based dosing guidelines for cases not referred to DocAssist. Dr. Goyal noted that the number of medications used as well as the number of medications exceeding dosing guidelines should be considered. Anitha Nagelli, PharmD noted that independent review will help practitioners and asked for clarification of which recommendations differed from the Washington guidelines. Mary Lynn Moody, BSPHarm, provided the example of methylphenidate, where the maximum daily dose was lowered to 108 mg for children 12-18 years of age, compared with the 120 mg max daily dose in the Washington guidelines. Dr. Tulley made a motion, seconded by Tim Lehan, BSPHarm, and the DUR Board unanimously approved DocAssist peer support based on the developed dosing guidelines.

**Benzodiazepine use in patients filling narcotics.** Christina Petrykiw, PharmD addressed a potential prospective edit related to safety of concomitant benzodiazepine and narcotic use. As discussed previously, up to 75% of patients who abuse opiates, also use benzodiazepines concomitantly. In methadone users who are coprescribed benzodiazepines, an enhanced opiate-induced euphoria occurs. Increased prescribing of benzodiazepines with narcotics has been seen from 2002 to 2009 in primary care clinics and Emergency rooms (ERs). Concomitant use often occurs due to different prescribers seeing the same patient. Concomitant use has increased overdose risk due to respiratory depression, since benzodiazepines lower the threshold for respiratory depression and may also increase opiate levels. When the DUR Board previously reviewed data, in the first quarter of calendar year 2015 almost 1,700 participants were getting both drug classes in the same month. The most common narcotic was hydrocodone in combination with acetaminophen or ibuprofen and the most common benzodiazepine was alprazolam. After methadone became non-preferred in 2016, prescribers needed to submit methadone pain management program forms to obtain prior authorization. At least 15% of the denials were in part due to benzodiazepine use. Alprazolam-related ER visits have increased from 2005 to 2011 significantly in all age groups. At least 32% of patients visiting the ER due to alprazolam, narcotic pain relievers were also implicated. In patients going to the emergency room due to 2 or more drugs, narcotics were present in 57% of patients. The FDA requires a Black Box warning about serious risk and death when opioid-containing pain or cough medications are combined with benzodiazepines. The combinations should only be used if alternative treatment options are not sufficient. If prescribed together, the dosages and durations of each drug should be limited to the minimum needed to achieve the desired clinical effect. Patients and caregivers should be warned about risk of slowed or difficult breathing and/or sedation and taught the associated signs and symptoms. Opioid-containing cough medications should not be prescribed for patients taking benzodiazepines, CNS depressants, or drinking alcohol. Management of combined benzodiazepine and narcotic use varies among treatment sites and state Medicaid agencies. Narcotic addiction treatment centers do not allow benzodiazepine therapy due to potential for addiction. Hydroxyzine is prescribed for anxiety instead of benzodiazepines. State Medicaid agencies have required prior authorization for use of methadone if a benzodiazepine is being taken or prior authorization for use of a benzodiazepine if an opioid or Suboxone are taken. Other states implement DUR edits when 4 CNS depressant classes (including benzodiazepines and opioids) are taken at the same time and notify prescribers about risks of adverse events when the combinations are used. Some states limit the number of controlled substances allowed in 30 days, for example no more than 4 substances. Managed care organizations have used combination therapy with benzodiazepines and opioids as a marker to evaluate the patient for lock-in to one prescriber and pharmacy. The DUR Board members discussed aspects of an edit that would be activated when concomitant therapy was prescribed in the same month. Dr. Tulley noted that this may frequently be due to different prescribers seeing the same patient. The DUR Board members wanted to better understand the current volume of patients receiving an opioid and benzodiazepine in the same month. They were concerned about volume of prior authorization requests that would be generated and what the prescriber requirements would be. More clarity was desired about what the PBMS can do if these medications are on the PDL. Dr. Goyal noted that prescriber education is needed. The Illinois Prescription Monitoring Program data shows that one third of prescriptions are for opiates and benzodiazepines usually prescribed by more than one prescriber. Significant use of multiple pharmacies may require application of lock-in criteria. A comprehensive opiate and benzodiazepine policy would be needed to help prescribers treat patients appropriately.

### **Education**

**Use of non-statins.** Christina Petrykiw, PharmD, reviewed the updates to the educational item about high cholesterol and use of non-statins. The cardiovascular risk calculator and clinical trials for Omega-3 fatty acids were incorporated as requested by the DUR Board. Dr. Caskey made a motion, seconded by Anitha Nagalli, PharmD, and the educational item was approved for posting on the DUR Webpage.

### **2.15.17 Illinois Drug Utilization Review Board Meeting Summary**

**Montelukast's role in the treatment of asthma.** Christina Petrykiw, PharmD reviewed the educational item requested by the DUR Board regarding montelukast's role in the treatment of asthma. The primary focus was on existing guidelines for use of montelukast from the National Heart, Lung, and Blood Institute, the Global Initiative for Asthma, and the practice parameter from the Joint Task Force representing the Academy of Allergy, Asthma and Immunology, the American College of Allergy, Asthma and Immunology, and the Joint Council of Allergy, Asthma, and Immunology. Montelukast is not first-line therapy and should be added as a second controller medication only after a sufficient therapeutic trial of first-line therapy (steroid inhaler). Expectations from HFS for asthma care by prescribers were highlighted. Anitha Nagelli, PharmD made a motion, seconded by John Tulley, MD, and the DUR Board unanimously approved posting the montelukast educational item.

**Educational materials on Website.** Christina Petrykiw, PharmD, showed DUR Board members screen shots of the redesigned DUR Webpage on which educational items are posted.

#### **Future agenda items.**

Dr. Caskey asked DUR Board members for additional medication use issues HFS should be evaluating, besides those recommended during discussions at this meeting. No additional issues were noted. The DUR Board members may forward issues they identify to Christina Petrykiw, PharmD.

**Public comments.** Dr. Caskey invited attendees to provide comments. There were no public comments.

**Adjournment.** Dr. Caskey adjourned the DUR Board meeting at 10:11 am.

Meeting summary prepared by Christina A. Petrykiw, PharmD, CDE.

**Approved May 17, 2017 by the Illinois Drug Utilization Review Board.**