

Drug Utilization Review Board Meeting Summary

Wednesday, May 17, 2017

The Drug Utilization Review (DUR) Board met on Wednesday, May 17, 2017, at 8:30 a.m. in Conference Room B-16, University of Illinois at Chicago College of Pharmacy, 833 S. Wood Street, Chicago, Illinois.

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; Zhen Ou, PharmD, UIC; Christina Petrykiw, PharmD, CDE, UIC; Linda Schuh*, BSPHarm, BPAS; Patricia Steward*, BSPHarm, BPAS.

Interested parties: Katie Breese PharmD candidate, UIC College of Pharmacy; Lisa Dunn, Amgen; Keith Huff, Novartis; Michael LaFond, Abbvie; Danielle Leonard, Johnson & Johnson; Marcia Luchett, Genentech; Mary Kanerster, Lilly; Ashley Polce, Abbvie; Kelsey Vandenberg, PharmD candidate, UIC College of Pharmacy.

*Attendance via teleconference

Call to Order. Rachel Caskey, MD, called the meeting to order on May 17, 2017 at 8:32 am.

Agenda, conflict of interest review, and approval of February 15, 2017 meeting minutes. Illinois DUR Board members had no changes to the May 17, 2017 meeting agenda or the February 15, 2017 minutes. Tim Lehan, BSPHarm, made a motion, seconded by John Tulley, MD, and the DUR Board unanimously approved the February 15, 2017 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, noted that the new web-based Pharmacy Benefits Management System (PBMS) has been live for about 6 weeks. The new system can facilitate step therapy and drug utilization review edits. In the Illinois Rx Provider Portal, prescribers can enter and view status of prior authorization requests. Visualization of patient vaccine information is much easier with the new PBMS system.

DUR Board update. Christina Petrykiw, PharmD, notified DUR Board members that Dr. Stacie Laff, a pediatrician, has joined the Board, but could not attend today's meeting due to previous practice commitments. Christina Petrykiw, PharmD, requested that DUR Board members vote to allow Dr. Laff to attend the Board meetings via teleconference due to difficulty of travel up to 6 hours to attend in person in Springfield or Chicago. Open Meeting Act requires meeting quorum to approve attendance via teleconference prior to beginning meeting discussions. Since this will be an ongoing issue for down-state attendees, DUR Board members were asked to vote to allow attendance for Dr. Laff on an ongoing basis via teleconference, rather than voting at each meeting. Tim Lehan, BSPHarm, made a motion, seconded by Anitha Nagelli, PharmD, and the DUR Board unanimously voted to allow Dr. Laff to regularly attend the DUR Board meetings via teleconference. Dr. Goyal, MD, suggested clarifying the impact of attendance via teleconference on meeting quorum. Mary Lynn Moody, BSPHarm invited physicians or pharmacists who are actively practicing in outpatient settings with significant Medicaid populations and may be interested in serving on the DUR Board, to reach out to Mary Lynn Moody, BSPHarm, at MLMoody@uic.edu or to Mark Huston, Chief, BPAS.

5.17.17 Illinois Drug Utilization Review Board Meeting Summary

ADHD and DocAssist update. Mary Lynn Moody, BSPharm, reviewed the availability of the University of Illinois at Chicago Department of Psychiatry DocAssist program for peer consultation. The DocAssist program provides a telephone hotline for prescribers related to mental health. DocAssist has been helping review stimulant dosing in cases of Attention Deficit Hyperactivity Disorder for 300 Medicaid participants who are 6 to 8 years of age. DocAssist is reaching out to prescribers of 65 participants receiving higher doses of stimulants and concomitant therapies to help determine appropriateness of therapy, dosing, and to help ensure accuracy of ADHD diagnoses. Non-ADHD mental health conditions with similar symptoms will not respond to stimulant therapy. At this time in approximately 50% of identified cases, reviews and consultations have been completed. In September 2017, outreach findings will be presented to the DUR Board. Children less than 6 years of age are not being addressed currently by DocAssist because prior authorization and accompanying review is already required for those participants. Dr. Goyal, MD, commended the great program and requested quarterly reporting of numbers of prescribers benefiting from the program.

Prospective Drug Utilization Review

Duloxetine PDL status. Christina Petrykiw, PharmD, informed DUR Board members that effective April 14, 2017 the serotonin-norepinephrine reuptake inhibitor (SNRI), duloxetine in 20-mg, 30-mg, and 60-mg strengths was added to the Preferred Drug List. The FDA-approved indications for duloxetine include major depressive disorder, generalized anxiety disorder, diabetic peripheral neuropathic pain, fibromyalgia, and chronic musculoskeletal pain. The currently available preferred SNRIs now include generic duloxetine, immediate-release venlafaxine tablets, and extended-release venlafaxine capsules.

Short-acting narcotics' monthly quantity edit. Christina Petrykiw, PharmD, notified DUR Board members that effective March 27, 2017 tramadol was added to the group monthly quantity edit that allows 186 dosage units of short-acting narcotics per month. Preferred short-acting narcotics that are now included in the group monthly quantity edit are products containing codeine, codeine with acetaminophen, hydrocodone with acetaminophen or ibuprofen, hydromorphone, meperidine, oxycodone with acetaminophen, and immediate-release morphine sulfate, oxycodone, and tramadol.

Retrospective Drug Utilization Review

Metformin use in patients with Type 2 diabetes mellitus. Christina Petrykiw, PharmD, provided an update regarding metformin use in patients with Type 2 diabetes mellitus (T2DM). In February 2017, the DUR Board had discussed the potential creation of a step therapy requirement for patients with T2DM that would require metformin to be first-line therapy consistent with evidence-based national guidelines from the American Diabetes Association, American Association of Clinical Endocrinologists, European Association for the Study of Diabetes, American College of Physicians, and International Diabetes Federation. The DUR Board members had requested more information about the number of patients that would potentially be impacted by a step therapy edit. During calendar year 2016, almost 17,587 HFS Fee-For-Service participants had a diagnosis of Type 2 diabetes mellitus. Up to 68% had a Type 2 diabetes mellitus diagnosis without complications, while the rest had complications such as diabetic neuropathy with or without arthropathy (15%), diabetic nephropathy or renal complications (7%), circulatory problems (2%), peripheral angiopathy without gangrene (2%), hyperosmolarity (1%), and less than 1% each had ophthalmic complications or hypoglycemia with coma. At least 91% of participants had one diagnosis, others had between 2 and 7 diagnoses. Approximately 93% of participants with one T2DM diagnosis filled metformin compared with 6% of those with two T2DM-related diagnoses. One percent or fewer patients with 3 or more T2DM diagnoses filled metformin, which can be expected if they had progressed to requiring insulin. Approximately 57% of patients with Type 2 diabetes mellitus without complications were taking metformin. The percent of patients with T2DM with complications who were filling metformin varied from 35% for those with hypoglycemic coma to 58% for those with non-detailed complications. Patients with T2DM filling metformin who had neuropathy, nephropathy/renal complications, ophthalmic complications and circulatory complications/peripheral angiopathy were reviewed. Overall, in calendar year 2016, 55% of all patients with T2DM filled metformin. The dosage forms filled were the 500-mg tablet (41%), 1000-mg tablet (37%), extended-release 500-mg tablet (13%), and the 850 mg tablet (5%). Less than 2% of fills were for the extended-release 750-mg or 1000-mg tablets. Almost 88% of participants filled only one strength or formulation, 12% filled two formulations, and less than 1% filled three or four formulations during the year. About 53% of participants filled 4-11 metformin prescriptions, while only 10% filled 12 scripts during the year. Approximately 36% of participants filled 1-3 prescriptions during calendar year 2016. Inherent gastrointestinal upset/diarrhea that may accompany start of

5.17.17 Illinois Drug Utilization Review Board Meeting Summary

metformin therapy may have contributed to lack of therapy continuation. The extended-release formulation helps decrease the occurrence of gastrointestinal effects. Based on filled claims review, the maximum number of participants who would be impacted by a step therapy edit are the 7,819 participants who did not fill any metformin during calendar year 2016. At this time it is unknown how many of these patients had tried/failed metformin therapy prior to 2016, have a contraindication to the use of metformin, other antidiabetic therapies they may be taking, and which participants may have a glycosylated hemoglobin level that would require insulin to be used first-line. The DUR Board members discussed the findings of the retrospective metformin review. The DUR Board felt that a step-therapy edit may be a good idea and may facilitate increase in usage since only about 50% of patients seem adherent with evidence-based guidelines promoting metformin as first-line therapy. Dr. Tulley suggested looking at about 200 of the participants that may be impacted by the step-therapy edit to determine therapies being used and getting input from their prescribers regarding metformin therapy. The DUR Board noted that although tolerance may develop to the gastrointestinal effects with metformin initiation, it was surprising that a low number were using extended-release formulations that can help decrease this side effect. Tim Lehan, BSPHarm, suggested potentially making only the extended-release formulation preferred to facilitate medication adherence. Participants currently filling and tolerating immediate-release formulation would not be required to switch to an extended-release formulation. The Preferred Drug List status would have to be determined by the Drugs & Therapeutics Committee. There may be a need to educate prescribers about preferred status of extended-release metformin formulations and ways to ameliorate gastro-intestinal side effects to improve medication adherence. Dr. Goyal requested clarification whether metformin was FDA-approved for managing prediabetes. Dr. Goyal felt that step-therapy may be recommended, not required. Dr. Goyal notified DUR Board members that Illinois is participating in an 18-month federal CMS Diabetes Prevention and Management Affinity Group. A plan for improving care of patients with diabetes is expected from the affinity groups in the fall of 2017. Additionally the Illinois Department of Public Health received a grant to strengthen state systems to improve Diabetes Management outcomes. Recommendations are expected from this group in fall 2017 also.

Benzodiazepine use in patients filling narcotics. Christina Petrykiw, PharmD provided updated information DUR Board members had requested regarding concomitant benzodiazepine and narcotic use. Benzodiazepines and narcotics individually can cause respiratory depression. Combination therapy with benzodiazepines and narcotics increases risk of potentially fatal respiratory depression further as highlighted by the FDA required black box warning effective August 31, 2016. Benzodiazepines also lower the threshold for respiratory depression and increase opiate levels based on shared metabolic pathways. Combination benzodiazepine and methadone therapy also worsens short-term/working memory. The FDA recommends limiting opioid combination therapy with benzodiazepines or other CNS depressants to patients in whom alternatives are not adequate. If concomitant use is required, the dosages and durations of each drug should be the minimum possible to achieve needed clinical effects. Patients/caregivers should be warned of risks of slowed or difficult breathing and/or sedation as well as associated signs and symptoms. The FDA also recommends avoiding prescription opioid cough medicines in patients taking benzodiazepines or other CNS depressants, including alcohol. During calendar year 2016, 388 participants filled a benzodiazepine and an opioid in each month of 2016 (0.65% of all participants filling benzodiazepines and 0.26% of all participants filling opioids). Similar to the 2015 data, the most common opioid was hydrocodone with acetaminophen (81%), followed by tramadol (16%), then oxycodone with acetaminophen (15%) and codeine with acetaminophen (5%). The most common benzodiazepine remains alprazolam (64%), followed by clonazepam (22%), diazepam (16%), lorazepam (13%), and chlordiazepoxide (<1%). It is unclear whether patients receiving clonazepam are taking it for seizure disorders or anxiety. Other questions include whether first-line therapy for anxiety (a SNRI or Serotonin selective reuptake inhibitor (SSRI) are being taken, whether one or multiple prescribers are providing these therapies, and whether one or multiple pharmacies are being used to fill the prescriptions. The DUR Board discussed whether to conduct a retrospective review of these participants to determine clonazepam indication, use of first-line SSRI/SNRI therapy, and existence of multiple prescribers or pharmacies. Additional discussion revolved around creation of an edit that would require prior authorization for any opioid in patients filling alprazolam or for any patient filling hydrocodone for whom a benzodiazepine is requested; a duration of therapy edit for benzodiazepines; prescriber outreach, and an educational item for prescribers regarding concomitant benzodiazepine and opioid therapy. Dr. Goyal informed DUR Board members that the Illinois Opioid Crisis Response Advisory Council created in January 2017 has a subcommittee addressing Prescribing Practices. Subcommittee recommendations will guide state officials in the development and implementation of a statewide Opioid Strategic Plan. Recommendations are to be provided to the governor July 1, 2017. The DUR Board members tabled decisions regarding edits until the recommendations are known. HFS to continue retrospectively reviewing the 388 patients receiving concomitant benzodiazepine and opioid therapy monthly.

5.17.17 Illinois Drug Utilization Review Board Meeting Summary

Education

FDA contraindication for use of codeine and tramadol in children. Christina Petrykiw, PharmD, informed DUR Board members that the FDA has updated the Drug Safety Communication regarding restricting the use of prescription codeine pain and cough medicines and tramadol pain medicines in children. The FDA has made use of codeine and tramadol in children younger than 12 years of age a contraindication. Additionally tramadol is contraindicated for use in children younger than 18 years of age to treat pain after tonsillectomy and surgery to remove adenoids. The FDA warns against use of codeine and tramadol in adolescents 12 to 18 years of age who are obese, or those who have obstructive sleep apnea or severe lung disease because these medications may increase risk of serious breathing problems in these conditions. The FDA also recommends against use of these medications in women who are breastfeeding. Dr. Caskey requested a vote and the DUR Board unanimously agreed that a link to the FDA Drug Safety Communication be posted on the DUR Board Website.

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 9:55 am.

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

Approved 9/20/2017 by the Illinois Drug Utilization Review Board.