ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Drug Utilization Review Board
Meeting Summary
May 19, 2022

The Drug Utilization Review (DUR) Board met on Thursday, May 19, 2022 at 8:30 a.m. via Web-ex for all attendees.

DUR Board members in attendance: Christopher Schriever, PharmD, Chairperson; Radhika Sreedhar, MD, Vice-chairperson; Aneet Ahluwalia, MD; Sam An, PharmD; Erica Stevens, PharmD.

Illinois Department of Healthcare and Family Services (HFS) Representatives: Jen DeWitt, BSPharm, HFS Bureau of Professional and Ancillary Services (BPAS); Donna Clay, BSPharm, Prior Authorization, University of Illinois Chicago (UIC); Jose Jimenez, Bureau Chief, BPAS; Arvind K. Goyal, MD, Medical Director, Medical Programs, HFS; Mary Lynn Moody, BSPharm, UIC; Christina Petrykiw, PharmD, CDCES, UIC; Jonathan Samardzich, PharmD, UIC.

Guests: Nikki Asse, Novo Nordisk; Santreis Booze, Global Blood Therapeutics; John Bullard, Alexion; Jenny Carrell, Johnson & Johnson; Riley Clark, Artia Solutions; Thomas Erikson, Bristol-Myers Squibb; Kelly Hamilton, Takeda; Michael Hawks, Alkermes; Jeff Knappen, Spark; Doug Johnson, Global Blood Therapeutics; Jomy Joseph, Sanofi; Mary Kaneaster, Gilead; Robert Kilo, Biogen; Ken Ring, Amgen; James Sharp, Intra-Cellular Therapies Inc; Lisa Tracz, Global Blood Therapeutics; Jason Vandervest, Vertex; Ryan Voyles, Healthline News Illinois; Bobby White, Eisai; Brooke Wilkins, Novartis; Shauna Williams, Bayer.

Call to order. Christina Petrykiw, PharmD, noted that the meeting will be recorded in accordance with adjustments to the Open Meeting Act. Guests wishing to speak at the end of the meeting were asked to type their name, affiliation, and that they would like to speak in the Web-ex chat. Speakers will speak in the order listed. Dr. Schriever called the meeting to order on May 19, 2022 at 8:34 am.

Roll call. Dr. Schriever verified presence of each Board member.

Agenda, conflict of interest review, and approval of February 17, 2022 meeting minutes. No changes to the May 19, 2022 agenda or the February 17, 2022 meeting minutes were requested. Dr. An's motion, seconded by Dr. Stevens, to accept the February 17, 2022 meeting minutes and the May 19, 2002 agenda were approved unanimously. No DUR Board members had conflicts of interest pertinent to the agenda. Dr. Schriever reminded DUR Board members to recuse themselves from discussion if conflicts of interest present and to provide an updated *Conflict of Interest* form if new conflicts arise.

Announcements/Updates

Pharmacist prescribed oral antivirals for COVID-19. Christina Petrykiw, PharmD, reviewed the HFS March notice about prescribing the oral antivirals, Paxlovid and molnupavir, by pharmacists for COVID-19. More information is available in provider notices posted on the HFS COVID-19 Web page at https://www2.illinois.gov/hfs/Pages/coronavirus.aspx.

Illinois ADVANCE – new resource for prescribers. An April HFS notice highlighted the free resource for prescribers, Illinois ADVANCE, that the DUR Board learned about in previous meetings. Illinois ADVANCE offers one-on-one, in-person or virtual visits with a clinical pharmacist, a Web-based curriculum of accredited CME programs, and drug information services. More information is available at https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/prn220404a.aspx.

Edits. The initial opioid and benzodiazepine days supply edits proposed are undergoing HFS administrative review to ensure both Fee-for-Service and Managed Care Medicaid put the same edits in place.

Retrospective DUR

Naloxone prescriber outreach for patients receiving high opioid MME prescriptions. The SUPPORT Act noted that persons at high risk of opioid overdose should be considered for co-prescription or co-dispensing of an FDA-approved opioid antagonist/reversal agent. One high risk characteristic is an opioid dose that is at a morphine milligram equivalent (MME) of 50 or greater since those doses are associated with a 2 or greater risk of an overdose compared with taking an opioid 20 MME dose. It is recommended to evaluate risk versus benefit of opioid therapy once the dose is at 50 MME/day and to have good justification if titrating the dose to more than 90 MME/day for non-cancer pain. Naloxone can be offered when MME is 50 MME or greater to decrease risk of fatal overdose with therapeutic opioid use. Participants filling opioids at 50 MME or greater from November 2020-November 2021 who had FFS coverage for at least part of that time were reviewed. About 27% of the patients had received a naloxone prescription at least once via HFS. Outreach was conducted for the high-risk participants who had never filled naloxone. During Phase 1 (January-February 2022) three naloxone fills occurred. The DUR Board had recommended to continue outreach and to incorporate a request for pharmacists to implement the standing order, particularly if the participant was receiving opioids at a 90 MME dose or greater. Education regarding the pharmacy standing order and hard edits were deemed worthwhile considerations during the February meeting. During Phase 2 (March-May 2022), naloxone fill history via HFS and Illinois Prescription Monitoring Program was determined and the prescriber contacted. After a month, a naloxone check was conducted, and the prescriber re-contacted. After a week, if no naloxone filled, the pharmacy was contacted with a request to implement the naloxone standing order. Subsequently the participant profile was checked for naloxone fills. For 20% of the participants in the intervention, naloxone was not deemed applicable for patient, medication, prescriber, or pharmacy reasons. Overall, 33% of the prescribers returned faxes and 29% of the naloxone eligible participants filled naloxone to date. Some fills are pending a prescriber discussion, appointment, or participant pick up of the prepared naloxone. This reflects a 15% increase in high-risk participants who have received naloxone.

Prescriber fax responses were reviewed with the DUR Board. Prescribers were aware of some concomitant conditions or medications that the participant had that further increased accidental opioid overdose. Some had previously discussed or prescribed naloxone. Some patients refused the naloxone. As a result of the intervention more participants were told about the naloxone standing order facilitating naloxone receipt at the pharmacy. The DUR Board discussed frequency of naloxone checks for the current group of prescribers and referral of prescribers to Illinois ADVANCE for 1:1 academic detailing about naloxone and opioid co-prescribing, continued use of the high MME reports to identify high-risk participants, and pharmacy manager or corporate pharmacy outreach. Dr. Sreedhar noted that the intervention is time intensive and resulted only in a third of the participants filling naloxone. Mandating pharmacy co-prescribing via the standing order may be better than prescriber outreach. Dr. Schriever agreed the intervention demonstrates due diligence but may have diminishing returns. It is unclear if can get 100% of the participants to receive naloxone. The Board discussed use of a hard edit, increased education and training of pharmacists, and legislation as potential methods to increase co-prescribing. Several naloxone-related laws are pending Governor Pritzker's signature. Upon request, it was clarified that all of the reviewed patients had chronic pain, including some oncologic diagnoses. Some of the patients had been tapered off opioids. The Board members noted that creating a template with a standing order set and opioid contract that can be implemented at the EMR/EPIC level can be useful and that technology-based solutions to help prescribers should be implemented. Naloxone co-prescribing could be the default. Dr. Stevens noted ongoing institutional initiatives. Prescribers should reach out to their EMR teams. Issues like autocalculating MME and offering naloxone co-prescribing options are helpful. A wait and see approach given pending legislation was deemed appropriate at this time as were periodic naloxone fill checks. Dr. Schriever recommended continuing the current process and providing a follow-up in 3-4 months. Dr. An seconded this motion and it was approved.

Historic naloxone fills. The DUR Board discussed when it may be appropriate to ensure a prescription for naloxone is given again since this was a question some of the prescribers have asked. Missouri requires a documented history of naloxone in the last 2 years. Data shows extended stability thus the FDA has increased the expiration for naloxone from

2 to 3 years. Dr. Schriever noted that annually may be good. Even if not using, it is beneficial to have it in the household where high-dose opioids are present. Dr. An noted that an annual requirement is an easy checkpoint to remind a patient when naloxone would be appropriate to use and signs/symptoms of opioid overdose. Dr. Goyal noted that naloxone co-prescribing initially in CDC guidelines was recommended because prescription opioids were driving the epidemic. Opioids may now be prescribed less. Currently the epidemic is driven by illicit opioids. Patients cannot administer naloxone to themselves- need a family member, friend, or drug provider to administer. Instituting a hard stop for participants filling high-dose opioids would most likely result in patients turning to illicit opioid use. There is a need for prescriber, patient, and insurer education. Information that is lacking is data comparing incidence of opioid overdose and death between patients who were co-prescribed naloxone and those who did not have naloxone co-prescribed. Dr. Goyal commended the board for being judicious in their recommendations. Dr. An recommended reaching out at least annually to determine if opioid harm reduction discussions and naloxone co-prescribing have occurred. Motion approved to look back yearly to see if patients have filled naloxone.

Additional high-risk patient groups recommended by the Surgeon General for naloxone co-prescribing were reviewed. Participants with concomitant opioid and benzodiazepine use will be addressed next. It will be determined whether the current edit can be adjusted to provide a message recommending naloxone co-prescribing. Board members recommended determining number of patients for whom prescriber outreach would need to be done. Various Chicagoland and downstate efforts are being conducted to ensure naloxone availability where needed.

Antidiabetic medications and Type 2 diabetes mellitus (T2DM) comorbidities. The demographics of T2DM in Illinois and Medicaid were reviewed. Percent of Medicaid participants with T2DM and comorbid conditions such as atherosclerotic cardiovascular disease (ASCVD), chronic kidney disease (CKD), or heart failure parallel trends seen in the overall national population of patients with T2DM for comorbid ASCVD and CKD, while less co-morbid heart failure is evident in the Medicaid population. Evidence-based drug therapy guidelines from the American Diabetes Association were reviewed for patients with T2DM and these comorbid conditions. Usage of glucagon-like peptide-1 receptor agonists (GLP-1RA) and sodium-glucose co-transporter 2 inhibitors (SGLT2i) was reviewed in FFS and MCO Medicaid participants for the July to December 2021 time frame. The GLP-1RA are being filled by 4% to 6% of participants with T2DM and a comorbid condition, while SGLT2is are filled by 6% to 7% of these patients. Overall, up to 13% of participants are receiving guideline recommended therapies. Dr. Sreedhar asked whether only certain GLP-1RA strengths are preferred on the PDL and if oral semaglutide is also effective since oral therapy is frequently preferred. For ASCVD, clinical trial evidence supports use of injectable GLP-1RA. Trials with oral semaglutide are pending and it cannot be recommended at this time. Significant glycemic lowering and weight loss are evident with oral semaglutide. Both strengths are preferred on the universal Medicaid PDL. Education is one avenue for increasing uptake of these medications. Erica Stevens, PharmD, is seeing need for teamwork from different disciplines to ensure the medications are given safely. She anticipates usage to increase. Prescribers are aware that something must be done, but they need to determine pathways to deliver care safely. Dr. Schriever recommended outreach starting with participants who have multiple co-morbidities. A letter that identifies the conditions and asks the patient to discuss possible therapy with their prescriber would be ideal. An education campaign not needed if can identify who are participants that will benefit and have them discuss with their prescriber. Contraindications can be listed in the letters. Outreach can then be conducted with the prescriber and the patient.

RetroDUR 300. An update provided on the most recent reviews. About 48 issues warranted prescriber outreach. Subtherapeutic doses and duplicate therapy were the main problems. Medications identified with these problems were highlighted.

Concomitant incretin mimetic therapy. Guidelines for glycemic control using sequential vs combination therapy were reviewed. Addition of a second medication improves A1c lowering about 1%. Addition of a GLP1-RA to a DPP4-inhibitor (DPP4-i) does not lower glucose as much as other combinations. Usage of GLP1-RA and DPP4-i alone and in combination in the HFS population was reviewed. About 7% of patients were receiving both medications during the 6-month review period. The DUR Board members felt patients filling both drug classes for 3 or more months or those who were alternating medication fills every month would be targets for prescriber intervention.

Education

Concomitant GLP1-RA and DPP4-i. Two articles are available for prescriber education- a one-page pharmacy article that summarizes the issues with combination therapy and a case series that did not support improved efficacy with combination therapy. The DUR Board members felt the 1-page summary sufficiently described the issue and that the case series would not be read. Dr. Sreedhar made a motion to post the article and use it for outreach with prescribers of patients filling these medications concomitantly. Dr. An seconded the motion and it was unanimously approved.

Future agenda items. The DUR Board members mentioned new guidelines published in the Annals of Internal Medicine regarding management of alcohol use disorder and opioid use disorder. In general, therapy for these disorders is underutilized. Alcohol use disorder is more prevalent and gabapentinoid use in alcohol use disorders may be worthwhile to review since usage is increasing for this off-label use. Dr. Schriever recommended potentially looking at utilization of long-acting HIV medications being used for HIV prevention and treatment.

Public comments. Dr. Schriever noted public comments should pertain to the agenda. No public comments received.

Adjournment. The DUR Board unanimously approved Dr. Schriever's motion, seconded by Dr. Sreedhar, to adjourn the meeting. The meeting was adjourned at 10:18 AM.

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

Approved November 17, 2022 by the Illinois Drug Utilization Review Board.