ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Drug Utilization Review Board
Meeting Summary
February 18, 2021

The Drug Utilization Review (DUR) Board met on Thursday, February 18, 2021, at 8:30 a.m. via Web-ex for all attendees pursuant to P.A. 101-0640: 5 ILCS 120/7 (e) and the 2-5-2021 Gubernatorial Disaster Proclamation due to the COVID-19 pandemic.

DUR Board members in attendance: Stacie Laff, MD, Chairperson; Christopher Schriever, PharmD, Vice-Chairperson; Aneet Ahluwalia, MD; Bedrijka Nikocevic, PharmD; Radhika Sreedhar, MD; Erica Stevens, PharmD.

Illinois Department of Healthcare and Family Services (HFS) Representatives: Donna Clay, BSPharm, Prior Authorization, University of Illinois at Chicago (UIC); Jen DeWitt, BSPharm, HFS Bureau of Professional and Ancillary Services (BPAS); Sheri Dolan, BSPharm, BPAS; Jose Jimenez, Bureau Chief, BPAS; Arvind K. Goyal, MD, Medical Director, Medical Programs, HFS; Kathy Kasiurak, PharmD, UIC; Mary Lynn Moody, BSPharm, UIC; Karla Nesnidal, PharmD, UIC; Christina Petrykiw, PharmD, CDE, UIC; Jonathan Samardzich, PharmD, UIC; Maurice Shaw, PharmD, UIC; Patricia Steward, BSPharm, BPAS; Lori Uildriks, PharmD, BCPS, BCGP, UIC;

Interested parties: Tammy Bima, Genentech Inc.; Chad Blomgren, Gilead; John Bullard, Alexion; Joseph Cirrincione, Otsuka; Dan Coleman, Merck; Karen Floeder, Biohaven Pharmaceuticals; Paul Ford, Johnson & Johnson; Sara Gao, AstraZeneca; Sakib Hassan, AbbVie; Michael Hawks, Alkermes; Sunny Hirpara, AstraZeneca; Douglas Johnson, Sobi; Mary Kaneaster, Gilead; Robert Kilo, Biogen; Lidiya Kizyma, UIC; Jessica Kulawiak, UIC; Michael LaFond, AbbVie; Linhong Long, UI Health; Huzefa Master, Meridian; Keith O'Hara, Otsuka; Donna Osterlund, Sanofi; Hunter Patton-Gentert, UIC; Elizabeth Plouff, UCB, Inc.; Ken Ring, Amgen; Carmel Schwalm, Takeda; Aaron Shaw, Boehringer-Ingelheim; Cyndi VanSteenburg, Molina; Thomas Vayalil, Molina Healthcare; Chase Williams, Gilead; 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. Laff called the meeting to order on February 18, 2021 at 8:34 am.

Roll call. Dr. Laff verified presence of each Board member. Christina Petrykiw, PharmD, verified presence of HFS staff.

Agenda, conflict of interest review, and approval of November 19, 2020 meeting minutes. No changes to the February 18, 2021 agenda or the November 19, 2020 meeting minutes were requested. Dr. Schriever's motion, seconded by Dr. Nikocevic, to accept the September 17, 2020 minutes and the November 19, 2020 agenda, was approved unanimously. No DUR Board members had conflicts of interest pertinent to the agenda. Dr. Laff 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

Board member training. Christina Petrykiw, PharmD, thanked DUR Board members for completing their training and informed them that the required annual training including Ethics for Appointees to State of Illinois Boards, sexual harassment, the Health Insurance Portability and Accountability Act provisions, and security awareness, will now be available via OneNet throughout the year and may be completed at any time, not just at the end of the year.

DUR Annual report. The DUR Annual report for Federal Fiscal Year 2019 submitted September 2020 is now posted on the Centers for Medicare and Medicaid Services website at https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/drug-utilization-review-annual-report/index.html.

Meeting schedule. The DUR Board meeting schedule for 2021 is posted on the HFS DUR Board Webpage at https://www.illinois.gov/hfs/About/Boa21, 2021 the rdsandCommisions/DUR/Pages/MeetingSchedule.aspx.

Extension of pandemic emergency. Effective January 21, 2021, the Secretary of Health and Human Services extended the determination that a public health emergency exists due to the Coronavirus Disease 2019 (COVID-19) pandemic. On February 5, 2021, Governor Pritzker extended the disaster proclamation regarding the COVID-19 pandemic for Illinois. The DUR Board meetings will continue via Web-ex for the duration of the pandemic emergency.

Lidocaine patch. The Preferred Drug List status of the lidocaine 5% patch was changed effective December 14, 2020. This product is now a preferred covered treatment option for pain management.

Prospective DUR

Extended-release alprazolam. At the November 2020 meeting, the DUR Board suggested HFS make extended-release (ER or XR) alprazolam preferred, instead of the immediate-release (IR) formulation, to help decrease IR alprazolam utilization. Alprazolam could then still be used when appropriate, but risk of diversion due to high street value would decrease. Karli Nesdinal, PharmD, reviewed issues with alprazolam use and misuse, indicated that guidelines recommend short-term use only, and compared indications, dosing, side effects, and pharmacokinetics of IR and ER alprazolam. In September 2020, the FDA updated benzodiazepine black box warnings regarding concomitant opioid use, re-emphasizing abuse, misuse, addiction, dependence, and withdrawal reaction potential with these medications. Higher risk of dependence exists with longer duration of therapy (> 12 weeks) and doses higher than 4 mg per day, although dependence can also occur with short term use of doses up to 4 mg. Short-term, low dose use is advocated over chronic use. Christina Petrykiw, PharmD, reviewed Preferred Drug List status of alprazolam ER in 19 states. Only 3 states have it preferred, while California is the only state that does not have any alprazolam dosage forms preferred. Extended-release alprazolam is preferred with a quantity limit in Indiana; preferred based on diagnosis in New York, and preferred due to pharmacy lock-in program monitoring in Wisconsin. New York allows for anxiety if a selective serotonin reuptake inhibitor (SSRI) or serotonin and norepinephrine reuptake inhibitor (SNRI) is started first, for panic if concurrent antidepressant used, and only for 30 consecutive days to treat panic. Seven states have a 1 tablet daily limit, and six states allow 2 tablets per day. Short-term use has been defined as 14 days by the Veterans' Administration with a maximum of 4-6 weeks' use, 2-4 weeks by the United Kingdom and New York City guidelines, and 10 days by Pennsylvania prescriber guidelines. Medicaid programs vary in allowed durations of therapy depending on diagnosis, initial or chronic use, age, usage history, or whether a cross-taper or discontinuation taper is occurring. Durations of therapy range from 30 days to 12 months. In calendar year 2020, there were approximately 225,000 fills of alprazolam IR and 11 fills of alprazolam ER by HFS participants (FFS and MCO combined). Benzodiazepine prescriptions reviewed for Four Prescription Policy are checked for presence of opioids and first-line SSRI/SNRI therapy and recommendations to start first-line therapy are made as needed. A large portion of the patients receive benzodiazepines long-term, over a year. The DUR Board discussed current and possible new benzodiazepine edits and benzodiazepine utilization concerns:

- Crushing of alprazolam ER as a method to obtain IR alprazolam not seen in practice, but wide use of the ER formulation also not been seen to date since non-preferred for most insurers.
- Dr. Laff asked whether alprazolam ER provides benefits such as greater stability and adherence similar to ER

formulations of medications to treat attention deficit hyperactivity disorder (ADHD).

- Alprazolam prescriber specialty assessment has not been done, but volume of claims suggests primary care prescribing since there is limited access to psychiatry. Primary care prescribers may not be aware that this is the most short-acting benzodiazepine and that the dependence potential makes it difficult to encourage patients to switch. Previous medical training was to prescribe benzodiazepines more liberally, only now is there more recognition of need to avoid benzodiazepines, particularly alprazolam.
- There appears to be lack of enthusiasm to prescribe SSRI/SNRI although they are recommended first-line agents.
- Dr. Ahluwalia noted patients ask for alprazolam and Xanax is known culturally. Brand name recognition of Xanax is a driver for requests as well, which may be why use of XR may be a good transitional agent and may be good to use for new starts or patients who are SSRI-resistant.
- Concern voiced that patients given ER formulation will complain that medication provides no relief and will not use it. Switching from alprazolam IR leads to less tolerance and complaints that the medication is not working well, so in Dr. Ahluwalia's practice they try to switch patients to diazepam which works quickly due to lipid solubility, but does not cause rebound since it is long-acting. If infrequent panic attacks, then prn alprazolam IR use may be appropriate, but if taking alprazolam 1-2 times per week, then starting a SSRI/SNRI is a good idea.
- Dr. Ahluwalia noted it would be appropriate to use ER if taking IR alprazolam for 6-12 months.
- Dr. Ahluwalia cautioned Board members to consider addressing the use before dependence occurs issue since hard to switch patients to other medications if they have already taken the IR formulation. He felt that the alprazolam ER and IR should be preferred, unless it is cost prohibitive. Dr. Stevens voiced concerns about rampant XR prescribing if XR preferred and 225,000 claims required to switch. Patients then complaining the ER formulation not working and this resulting in duplicate IR and ER prescribing is a concern. Dr. Ahluwalia did not think that ER prescribing would automatically increase if this was a treatment alternative to the IR formulation when both agents preferred. Only medical issues with use of alprazolam ER rather than IR may be longer duration of effect for flight anxiety than the flight itself, but the lower dose and lower peak would be beneficial. Longer morning sleepiness if using for insomnia, but that is not appropriate use for alprazolam.
- A duration of therapy limit that would require prior authorization to require use of other therapy after set period of IR alprazolam use was recommended. For example, taking alprazolam IR first, then if start taking TID and becomes a quality of life issue, then after 6 months switch to alprazolam ER. DUR Board members noted that if patients are transitioned from the IR to the ER formulation, may need to make IR alprazolam available temporarily to avoid withdrawal and an ER visit.
- The PBM system capability to identify how long a patient has taken alprazolam IR, then automatically approve the ER formulation was discussed. Something similar is done with the requirement of taking amoxicillin before being allowed to get Augmentin therapy by other insurers. The process is seamless and does not require the prescriber to fill out a prior authorization request. Possible SMART edits, utilizing a look-back period, diagnosis check for anxiety or panic disorder, or presence of SSRI/SNRI were suggested. Jennifer DeWitt noted that the lookback mechanism can be tested to see if doable or if a duration of therapy limit is more feasible.
- Dr. Sreedhar preferences include a diagnosis-based edit, step-therapy, age limit, and lastly an initial use duration of therapy edit. Dr. Ahluwalia noted that prescribers know in general that alprazolam used for anxiety management, so diagnosis edit not overly beneficial.
- A phased approach, educating pharmacy before effective date of changes would be needed if prior authorization were required for the IR formulation.
- Mary Lynn Moody suggested greatest harm is an uninformed prescriber. A continuing education program for prescribers that addresses the risks/benefits of chronic use, the IR vs ER forms, appropriate durations, pharmacokinetics, when and how both formulations should be used, and use of first line SSRI/SNRI therapy would be beneficial. It should also address patient concerns of not getting euphoria from long-acting version and if drug seeking is intent, prescriber tips for managing the conversation when the patient says medication not working.
- The high dose edit in place now limits all alprazolam tablets to 3 tablets per day. This translates to a maximum of 6 mg per day of alprazolam IR 2-mg tablets and 9 mg per day of alprazolam ER 3-mg tablets. Adjusting the high dose edit is very doable quickly.

The DUR Board members requested more clarification regarding how each edit will impact medication access. The DUR Board members also recommended evaluation of SSRI/SNRI in patients filling alprazolam and determination of who is prescribing alprazolam.

New DUR requirements. Christina Petrykiw, PharmD, reviewed part of the CMS-2482-F final rule that established minimum standards for state Medicaid DUR. The final rule clarifies the opioid-related provisions of the SUPPORT Act and adds new standards for 1) opioid use after a participant has been prescribed medication assisted treatment (MAT) for opioid use disorder (OUD) or has been diagnosed with OUD and 2) considerations for co-prescribing or co-dispensing of an opioid antagonist/reversal agent for participants at high risk of opioid overdose. **Opioid use and MAT.** The DUR Board members discussed timeframe between MAT therapy and use of an opioid to determine appropriate overlap or lookback periods before prior authorization is required. Currently, there is a 25-day lookback for short-acting opioids and MAT. HFS will check how many times a PA has been required for concurrent MAT and opioid therapy due to this edit. Dr. Ahluwalia reported that for MAT patients at Miles Square- concurrent opioids are rarely allowed. There are instances of chronic opioid use and dependence, in which case a 1-month overlap period is allowed for transition from opioid therapy to buprenorphine. Once patients start MAT, concurrent opioid therapy is not expected. Dr Goyal noted that if a trauma, i.e. bone break occurs, or surgery done, then the current guideline recommendation is to maintain MAT and add acute opioid therapy to help manage the pain short-term. Limiting the quantity or duration of opioids allowed concurrently with MAT and then requiring prior authorization if limits exceeded was suggested. There is no desire to have unmanaged acute pain until prior authorization is received. Capability to require a diagnosis to process a prescription was discussed. At this time, the diagnosis may be submitted, but will not be used to process the claim via an automated process. Dr. Laff noted that since January prescribers have been required to fill in a diagnosis code to ensure prescriptions for ADHD medications are processed. Dr. Nikocevic had seen this with Medicare or other insurers for other medications also. The pharmacist enters the diagnosis so that the prescription can be processed. HFS will investigate how the diagnosis can be incorporated in our system so that it can part of the prescription processing, not ignored. Alternatively review of rejections could be used to manually approve the claim, but this would be a retrospective, not point-of-sale process. **Naloxone co-prescribing/co-dispensing**. Board members noted that any history of OUD rather than just recent Emergency Room discharge for OUD as noted in Surgeon General recommendations should be a high-risk consideration. Claims review should be done for OUD every time an opioid is prescribed in these participants to ensure naloxone is available. Pharmacists have a role in backing up prescriber to ensure naloxone prescribed where appropriate based on standing order. There should be no added cost/copay, prior authorization requirement, or barrier to obtaining naloxone for Medicaid patients. Dr. Goyal reminded everyone that in case of an overdose, the patient will not be self-administering the naloxone, that others will need to administer and know where it is so administered in time. Public locations with naloxone, similar to defibrillator availability in community sites, are being piloted in 3 cities to determine if this makes an impact in treating opioid overdose cases. Strong educational effort with prescribers, pharmacists, and patients is needed regarding naloxone therapy. Mary Lynn Moody noted that the standing order allows family members or others, not just the patient, to receive naloxone. HFS uses a seizure diagnosis check for anti-epileptic medications and will check if something similar can be done for OUD. A manual lookback may also be possible for claims that meet high-risk criteria.

Education

Educational outreach to reduce dental opioid prescribing. Cynthia VanSteenburg, PharmD, provided an overview of Medicaid MCO Molina's educational outreach to reduce dental opioid prescribing. Opioid claims review evaluated prescribing by specialty, days supply, minimum effective dose, and risk of respiratory depression. High risk participants were reviewed during rounds. Educational peer-to-peer outreach was conducted with prescribing outliers. A 6-month retrospective DUR identified dentists prescribing 3-day, 5-day, and 7-day supplies of opioids. Outreach was conducted with dentists prescribing a 7-day or greater supply of opioids. An informational packet that outlines Centers for Disease Control and Prevention and American Dental Association recommendations and addresses treatment alternatives to opioids was provided to all network dentists. Overall dental claims decreased 18% from 2018 to 2019 due to the

intervention. Claims for more than a 5-day supply decreased 36% from 2018 to 2019 and for more than a 7-day supply claims were reduced by 67%. The trend seems to continue into 2020 with only 15 prescriptions for a greater than 7-day supply filled. It is unclear how much the COVID-19 pandemic is contributing to 2020 decreases in opioid prescriptions. Nonsteroidal anti-inflammatory drug (NSAID) claims, an alternative to opioids for dental pain management, have increased and surpassed opioid dental claims after the educational packets were distributed. Molina now provides monthly reports regarding dental opioid prescribing to the dental vendor and continues to monitor days supply and total opioid prescriptions. The model will be applied to other specialties to ensure appropriate days supply prescribed. The prescriber letter and additional educational materials provided to dental prescribers were reviewed. One CDC educational item educated patients regarding acute pain management. Mary Lynn Moody, BSPharm, mentioned that this initiative may be a good collaborative effort to implement across all Medicaid insurers in Illinois. Fee-for-Service data can be reviewed for comparison. Molina plans to address MAT therapy in obstetric-gynecologic patients, rheumatologists' use of opioids rather than disease modifying anti-rheumatism drugs (DMARDs), and post-surgical pain management. Dr. Laff made a motion, seconded by Dr. Schriever, to have Molina's dental opioid and opioid initiatives for other prescribing groups conducted as a collaborative initiative so that all HFS participants can benefit. The DUR Board members unanimously approved this motion.

Opioid-induced endocrinopathies. Christina Petrykiw, PharmD, briefly reviewed the educational item developed by Dr. Kasuriak about opioid-induced endocrinopathies that had been suggested by DUR Board members at the November 2020 meeting. Dr. Laff made a motion, seconded by Dr. Schriever, and the DUR Board approved posting of the article.

Illinois opioid data dashboard. Christina Petrykiw, PharmD, informed the Board members that the Illinois Department of Public Health and Illinois Prescription Monitoring Program collaborative Illinois Opioid Data dashboard has been recently updated. The dashboard provides data regarding opioid prescribing, opioid overdoses, subgroup analysis of trends, mortality trends by opioid involved, as well as facilitates identification of MAT prescribers and naloxone distribution sites in Illinois. The data is searchable at the county, city, and zip code level. Dr. Laff's motion, seconded by Dr. Stevens, to post links to the Illinois Opioid Data Dashboard on the DUR Board Education webpage was unanimously approved.

Future agenda items. Dr. Sreedhar recommended addressing which Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) and Sodium-glucose Cotransporter-2 (SGLT2) Inhibitors are on the preferred drug list since there is increased usage. Christina Petrykiw, PharmD, noted that the Illinois Medicaid Preferred Drug List has at least 2 medications in each drug class available on the Preferred Drug List. The antidiabetic medications can be addressed at a future DUR Board meeting.

Public comments. Dr. Laff noted public comments should pertain to the agenda. No requests for public comment received in the Webex chat. Mary Lynn Moody, BSPharm, informed DUR Board members of the launch of covidpharmil.org, developed by UIC College of Pharmacy and the Illinois Department of Public Health. The Website supports the collaborative Illinois COVID-19 Pharmacy Vaccine Task Force that helps deploy pharmacists for the COVID-19 vaccine response. The website is updated twice a week by the infectious disease experts at the College and provides educational information to pharmacists, pharmacy students, and pharmacy technicians who will be administering COVID-19 vaccines. The website also has information for the lay public. Dr. Laff noted that addition of a link that helps patients and prescribers locate the nearest vaccination site to make an appointment to get the vaccine would be helpful.

Adjournment. The DUR Board unanimously approved Dr. Laff's motion, seconded by Dr. Nikocevic, to adjourn the meeting. The DUR Board meeting was adjourned 10:12 AM.

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

Approved May 20, 2021 by the Illinois Drug Utilization Review Board.