ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Drug Utilization Review Board
Meeting Summary
May 20, 2021

The Drug Utilization Review (DUR) Board met on Thursday, May 20, 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 4-30-2021 Gubernatorial COVID-19 pandemic Disaster Proclamation.

DUR Board members in attendance: Stacie Laff, MD, Chairperson; Christopher Schriever, PharmD, Vice-Chairperson; Sam An, PharmD; 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; Mary Lynn Moody, BSPharm, UIC; Karla Nesnidal, PharmD, UIC; Christina Petrykiw, PharmD, CDCES, UIC; Jonathan Samardzich, PharmD, UIC; Sarah Schroeder, BPAS; Maurice Shaw, PharmD, UIC; Patricia Steward, BSPharm, BPAS; Lori Uildriks, PharmD, BCPS, BCGP, UIC;

Interested parties: None present.

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 and notified that a quorum was present.

Agenda, conflict of interest review, and approval of February 18, 2021 meeting minutes. No changes to the May 20, 2021 agenda or the February 18, 2021 meeting minutes were requested. Dr. An's motion, seconded by Dr. Sreedhar, to accept the February 18, 2021 minutes and the May 20, 2021 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

New Board member welcome. Christina Petrykiw, PharmD, welcomed Dr. Sam An who is present for his first meeting. Dr. An notified DUR Board members that he practices at Alwan Pharmacy & Compounding Center in Peoria. The DUR Board members introduced themselves and where they practice.

Prospective DUR

Order standardization for opioid prescribing. The article, Effect of order standardization on opioid prescribing patterns, was published in March 2021 in the journal, *The Joint Commission Journal on Quality and Patient Safety* (https://doi.org/10.1016/j.jcjq.2021.03.005). One of the authors was Dr. Sreedhar, a DUR Board member. Dr. Sreedhar provided DUR Board members information learned regarding opioid order standardization impact on prescribing

patterns, a concept pertinent for HFS prescribers. Dr. Sreedhar noted that the goal was to have the UI Health prescribers be in line with the Centers for Disease Control and Prevention (CDC) opioid prescribing guidelines. The statistic of over 1,000 persons being treated daily in Emergency Rooms for prescription opioid misuse complications had contributed to a desire to improve care. The CDC recommended using non-opioids when possible and using lowest effective opioid doses when needed. Order standardization aimed to restrict acute opioid therapy to 3 days and target opioid prescriptions that were more than 50 morphine milligram equivalents (MME). Thirty-eight percent of opioid misuse is opioid prescriptions or stealing opioids from prescriber. Up to 53% of subjects received the opioid from a friend or relative. Aim became to decrease the number of opioid prescriptions or opioid tablets that were prescribed. The Nudge theory has been used to influence behavior and decision-making regarding hydrocodone-acetaminophen. Prior to the intervention 1-2 tablets every 4 to 6 hours was allowed and no default quantity of tablets was present. The intervention used a new default order of 1 tablet every 6 hours as needed for pain with a quantity of 3 or 5 days (12 tablets or 20 tablets). Prescribers chose the dose, frequency and dispensed amount from a list and the default order was listed first. The number of orders decreased by almost a thousand and the average number of tablets decreased by over 65,000 tablets from the pre-intervention to the post-intervention period. The dosing frequency for prescriptions became every 6 hours (approximately 21% difference from pre-intervention. The number of scripts with more than a 3-day supply decreased by almost 3%, and the MME > 50 per day decreased by almost 6%. The MME changes and the 3-day supply changes were significant. The intervention did not cost anything, only needed an adjustment in the default order. Patient perspective how well pain was managed was not assessed during the intervention. Physicians accepted the intervention because this was not a formulary restriction and prescribing flexibility was an option to meet patient needs. Dr. Laff asked how this impacted favorites – did those need to be redone. Dr. Sreedhar noted that was not a prescriber complaint. The DUR Board members felt this was a good intervention. Order set was controlled at the hospital EMR level, unclear how could impact at HFS without having restrictions. Dr. Sreedhar suggested talking to the EMR providers to make this a standard default order set if the state has that influence. Dr. Petrykiw reviewed the existing opioid edits to ensure appropriate use. The UI Health intervention would result in a HFS quantity limit of 4/day or 120 per month rather than the current 6 per day or 180 per month or would require adjusting the MME down from the current 90 and 120. There was about a 1 month push back from patients when HFS instituted the current edits. For the initial opioid prescription, Dr. Sreedhar suggested limiting to 3 days because more can also be given if needed. DUR Board members discussed the initial opioid quantity for acute indications. Dr. An voiced concern regarding the patients who are considered acute because of insurer changes, while they have been using opioids chronically. HFS looks back for 3-6 months for Fee-for-Service, but MCO does not have to have the same initial day supply, only to have an initial days supply edit in place. Dr. Ahluwalia suggested a 5-day supply to ensure weekend supply available and this was deemed better for addressing voiced concerns since the 72-hour supply allowance for emergency use does not pertain to opioids. Pharmacies are risk averse and will either require payment or just allow the 3-day supply. Pharmacists may not be aware of the 72-hour supply rule for non-opioid medications or their pharmacy systems may not facilitate dispensing a 72-hour supply. HFS suggested getting data on the 7-day edit and how frequently prior authorization has been requested since the edit has been in place for over a year. If prescribers are used to it, it is easier to adjust. The DUR Board prescribers felt 5 days was appropriate to institute. Dr. Goyal noted that the days supply should be decreased per guidelines and no complaints received for the 7-day limit, so 5-days may be appropriate at this time. An announcement should include information about the CDC guidelines and remind that this is for opioid naïve patients requiring opioid therapy for acute, not chronic pain. The issue should be reviewed again in a year to see if complaints or other issues noted and see if can go down to 4, then 3 days. An incremental process would be helpful. Notice of 3-4 weeks for prescribers before the effective date of implementation is recommended. Dr. Sreedhar made a motion to approve change of the initial opioid days supply for opioid naïve patients from 7 days supply to 5 days supply. Dr. Nikocevic seconded the motion and the DUR Board unanimously approved the change. The MCOS will need at least 6 weeks notice. It was suggested to approve the concept and not have a specific implementation date so that HFS can work on all implementation procedures for the change and choose an appropriate effective date.

Dr. Sreedhar asked whether codeine and tramadol should continue to be preferred due to pharmacokinetic problems, as well as side effects, interactions, and acute withdrawal effects. Usage evaluation was suggested for these opioids as a first step. Lowering of MME was suggested since an MME of 50 is considered safer.

Retrospective DUR and Education

Dental opioid therapy duration. Jonathan Samardzich, PharmD, presented HFS dental prescribing for calendar year 2020. The American Dental Association recommends no more than 7-days of opioids for acute pain. During calendar year 2020, the majority of the 28,502 claims were in Medicaid MCO covered participants. The most common medications were acetaminophen with codeine and hydrocodone with acetaminophen. About 97.5% of claims were for less than 50 MME. The average MME was 23.2. At least 63% were for a 3-day supply or less, 93% for 5 days or less and 99.3% for 7 days or less. Only 192 claims 0.67%) were for more than a 7-days supply. This reflected 85 dentists. The majority of dentists did not prescribe for more than 7 days supply more than 1-2 times. A quantity of 30 was present in almost 77% of the greater than 7-days supply group. Only 11 claims exceeded an MME of 50 in 7 participants. Five of the participants had discontinued the therapy, one participant had cancer and one continued to get opioids (5 times in the last 6 months). The Pain Management Program will reach out to the prescriber. The participants filling greater than 7 days supply are not reflective of chronic therapy in 82% of participants. Those filling opioids chronically are being treated by the primary care provider for chronic pain and only 5 participants continue to receive chronic opioid therapy from a dentist for an average MME of 38 daily. It was noted that at this time current opioid safety edits and mandatory opioid education for license renewal sufficiently limited dental opioid prescribing to less than 7 days supply. Dr. Stevens asked whether any patients had filled a 3-5 days supply and then again filled another small days supply. This was not reviewed but can be reviewed in the future. The detailed analysis addressed exceeding 7 days supply only. On May 18, 2020 a 7-day initial opioid edit for opioid-naïve patients was instituted. During calendar year 2020, Fee-for-service paid for 11 prescription claims that exceeded the 7 days supply. Eight were before the edit began and only 3 claims were paid after the edit was put in place. Those claims went through because the participants were not opioid naïve. Dr. Goyal asked whether matched claims to any history of overdose or opioid use disorder in those who had higher MME was done or whether street drugs were used or addiction noted. Mary Lynn Moody noted that ILPMP can be reviewed for each individual patient to see if received naloxone or an overdose treatment. An update will be provided to the DUR Board. Donna Clay, BSPharm, asked whether the data presented was after the Molina project was completed. Since the same prescribers who received information within the Molina project see participants from all of the Medicaid insurers, this may explain why little problem was noted in the data. **Education.** As mentioned in February, Molina had provided The Center for Opioid Research and Education Dental Opioid Guidelines for common dental procedures and the CDC patient information resource about opioid use for acute pain to their dental prescribers. The Board members felt that even though the utilization review did not identify a problem at this time, for preventive opioid prescribing purposes, it was still good to post the information. The DUR Board members asked if the capability exists to determine number of clicks received for educational materials, since the DUR Website may not be the first place a prescriber would look for pain management materials. Dr. Sreedhar noted that active education has been found to be more effective than passive education. If it takes a lot of effort to maintain and not being used, need to consider benefit of maintaining. It was noted that maintenance of the page is doable, not excessive. Dr. Laff noted that use can be impacted by knowing a resource is available. Dr. Petrykiw noted that clicks to a page are counted, but not necessarily to an individual document. This information is shared in the DUR annual report and can be provided to the DUR Board members. Information about documents on the Website where more can be learned should be included in provider notices about edit changes. Multiple factors such as Molina's project, dissemination of CDC and dental opioid guidelines have contributed to improve opioid prescribing. Dr. Nikocevic made a motion, seconded by the Dr An and the Board unanimously approved posting the dental opioid prescribing information on the Website.

Naloxone in patients with high opioid MME. Christina Petrykiw, PharmD, presented naloxone use in patients with high opioid MME. Naloxone-related Illinois and federal legislation/guidance was reviewed. Claims for naloxone January 2010 through April 2021 were reviewed. Increased usage parallels legislative actions to expand naloxone availability. The naloxone spray was dispensed the most from 2016-2021 followed by naloxone injection and the Evzio injector which is no longer available. Naloxone prescribers by type were reviewed. Top prescribers were the chief medical officers on standing orders from the Illinois Department of Public Health and Walgreens. Addiction medicine, psychiatry, Family Medicine, and Emergency Medicine prescribers are also prescribing in various locales. Prescribing is highest in the Chicagoland area, followed by Springfield and Alton. Walgreens is the top pharmacy dispensing naloxone in the state.

Profiles of participants with high opioid MME of 50 and 90 identified via Change Healthcare reports were reviewed for naloxone prescription claims. Between 26 % to 40% of participants in these MME categories have filled naloxone in either FFS or MCO Medicaid. Standing orders accounted for 12% to 31% of the naloxone claims. The majority of participants filled 1-3 naloxone prescriptions. A few patients had up to 12 refills. Diagnoses for the 90 MME with 9 or more naloxone fills were trauma, sickle cell, chronic back pain, and one patient had a history of substance abuse and a current cancer diagnosis. The DUR Board members suggested potential ways to improve naloxone prescribing/availability for patients who may have a safety risk due to high opioid MME. Dr. Sreedhar asked if HFS can create a standing order for any patient who fills an opioid 50 MME or greater. Incorporating 50 MME prior authorization can help so not dependent on prescriber. The pharmacist adjudicating the opioid prior authorization could put in a naloxone order or work with the pharmacy to ensure a naloxone spray is dispensed. A prior authorization delay in obtaining pain medication was not deemed beneficial. The participants with high naloxone claims are concerning since unclear if getting for themselves or others and if truly understand what naloxone is and when and how to use it. Dr. Laff noted that she assumes patients don't understand its purpose if just automatically refilling. Giving refills can stimulate multiple fills. Dr. Nikocevic noted that in practice some patients need up to 4 doses of the naloxone to be revived. Targeting the high MME participants with education would be good, or at least educating the prescriber and providing them the materials to provide to the participant. There is no MME prompt when you write the prescription, so educating the prescriber and patient would be good. Standing order proven effective. Academic detailing regarding naloxone can be conducted with prescribers who have participants receiving 90 MME or greater. Need to make naloxone as accessible as possible. Pharmacies should also notify prescribers that naloxone was dispensed. Dr. Stevens recommended determining with the prescriber during academic detailing if their EMR prompts when prescribing high MME that naloxone should be prescribed. Informational edits for the pharmacy could be helpful if seen in current dispensing programs. Unclear if an information edit provides MME which would be a prompt for the pharmacist to offer naloxone. A third party DUR would prompt a need for pharmacist signoff. Dr. An noted that if claim goes through, few short staffed pharmacists will look for additional information. Dr. Shaw noted that Walgreens has a targeted drug good faith dispensing review worksheet that is required for oxycodone, hydromorphone, and methadone. It may be used with other opioid medications as well. If 50 MME or greater pharmacist must review if naloxone dispensed or offered. Walmart also has policy to give naloxone if risk of overdose or if addiction present.

Future agenda items. Based on today's discussion, tramadol and codeine usage, naloxone and over 90 MME follow-ups as well as Support Act implemented edits update would be addressed at future meetings.

Public comments. Dr. Laff noted public comments should pertain to the agenda. No requests for public comment received in the Webex chat.

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

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

Approved November 18, 2021 by the Illinois Drug Utilization Review Board.