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Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
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Nevada Medicaid
Drug Use Review (DUR) Board
Draft Meeting Minutes

The Division of Health Care Financing and Policy (DHCFP) Drug Use Review (DUR) Board conducted a public meeting on April 24, 2014 beginning at 5:30 pm at the following location:

BEST WESTERN AIRPORT PLAZA HOTEL
1981 TERMINAL WAY
RENO, NV 89502-3215

Board Members Present:
Paul Oesterman, Pharm.D., Chairman; James Marx, M.D.; Dave England, Pharm.D.; Jeff Zollinger, D.O.

Board Member Absent:
Larry Nussbaum, MD; Chris Shea, Pharm.D.

Others Present:
DHCFP:
Coleen Lawrence, Chief, Program Services; Mary Griffith, RN, Pharmacy Services Specialist; Darrell
Faircloth, Senior Deputy Attorney General;

HPES:
Beth Slamowitz, Pharm.D.

Catamaran:
Carl Jeffery, Pharm.D. Account Manager; Mariellen Rich

Others:
Alan Kaska, Abbott; Charlie Collins, Gilead; Sandy Sierawsky, Pfizer; Brooks Hubbard, BIPI; Marcus Laughlin, BIPI; Charissa Anne, J&J; Mary Kay Queener, J&J; Shane Hall, Purdue; Mike Stauffer, J&J; Camille Kerr, Allergan; Deirdre Monroe, Allergan; Betty Chan, Gilead; Melissa Walsh, Nova; Kim Laubmeier, Otsuka; Krystal Joy, Otsuka; Scott Larson, BMS; Lori Howarth, Bayer

1) Call to Order and Roll Call

Meeting called to order at 5:30 PM.

Roll Call:
Carl Jeffery, Catamaran
James Marx, MD, Las Vegas Pain Management and Addiction
David England, Pharm.D., Las Vegas
Paul Oesterman, Pharm.D. Reno
Darrell Faircloth, Deputy Attorney General
Jeff Zollinger, Pain Specialist in Reno
Mary Griffith, DHCFP
Coleen Lawrence, Chief Clinical Policy Team, Nevada Medicaid

2) Public Comment

None.

3) Administrative

a) Review and approve January 23, 2014 Meeting Minutes

James Marx, MD: requested the minutes to be more abstracted.
Paul Oesterman, Pharm.D., Chairman: Page 9, spelling correction for medication "Xeljanz."
Dave England, Pharm.D.: Moved to accept meeting minutes.
James Marx, MD: Second.
Board votes unanimous, "Aye."
Minutes approved.

b) Status Update by DHCFP

Coleen Lawrence: Provided updates on:

ICD-10. Implementation has been delayed another year. We are looking at 2015 now. The policy updates will still be coming to the Board for small changes.

CMS has asked states to do another State Plan Amendment for benzos and barbs for 2014. We will be submitting that. No policy changes with this, we are just keeping the State Plan up to date.

DHCFP has been preparing budget concept papers to our Director's office. They must be submitted by next week. There are a lot of ideas, provider rate increases, and some others.

Presentation of Clinical Steering Board

Based on practices and changes across the Board, HP presented this information and we're very impressed with the emergency room visits.

Beth Slamowitz, Pharm.D.: Called Ross Merritt, Senior Analytics Consultant, who put the presentation together but was unable to connect. Slides presented:

ER Frequent Fliers: Population Metrics

- Patients: 112
- Average Age: 41
- 51% Male (44% in all NV Medicaid)
- ER visits: 4,425 (39.5 visits per person)
- 93 patients with at least 1 inpatient admission (692 total admissions)
- Patients saw an average of 19 providers
- Patients filled 75 prescriptions each
- $7.1 million in net payments in FY 2013 (all services)
- More likely to reside in Elko County (11% vs 2%)

James Marx, MD: Are those 19 ER providers?
Beth Slamowitz, Pharm.D.: Those are 19 providers in general. They looked at the total claim history as a whole.

Most Common Diagnoses

- Resp Sys/Oth Chest Symp (93% of frequent fliers*)
- Other Abdomen/Pelvis Symp (91%)
- General Symptoms (83%)
- Other Soft Tissue Dis (71%)
- Symptoms Invol Head/Neck (69%)
- Back Disorder NED & NOS (67%)
- GI System Symptoms (63%)
- Joint Disorder NEC & NOS (62%)

*93% of patients had at least 1 ER visit with a primary diagnosis of Resp Sys/Oth Chest Symp (Dx Code 786.xx)

Chronic Conditions

Condition	Prevalence	Condition	Prevalence
Anxiety Disorder	34%	Diabetes	31%
Asthma	18%	Bipolar Disorder	36%
Congestive Heart Failure	19%	Coronary Artery Disease	23%
Complications	31%	HIV Infection	3%
Hypertension	47%	Low Back Disorder	65%
Depression	50%	Obesity	1%

- Everything is higher than average, except obesity, which is severely underdiagnosed.
- Notice the rates of conditions related to behavioral health
- The rates of heart disease, diabetes and hypertension are double or triple the Medicaid average

Beth Slamowitz, Pharm.D.: Everything is higher than the general population except obesity which is under diagnosed.

Prescription Drugs

- Forty-four percent (44%) of prescriptions are Central Nervous System drugs.
  - Analg/Antipyr, Opiate Agonists
  - Anticonvulsants, Misc
  - Benzodiazepines
  - Psychotherapeutics, Antidepressants
- Cardiovascular Agents (12%)
- Gastrointestinal Drugs (7%)
- Anti-Infective Agents (7%)
- Autonomic Drugs (6%)

Prescription Drugs – Top 10 by Net Payments, 2013

ER Frequent Fliers

Product Name	Therapeutic Class General	Net Pay	Patients	Days Supply
Ahiple	Anti-Infective Agents	$22,279	1	360
Dronabinol	Gastrointestinal Drugs	$17,199	2	360
Abilify	Central Nervous System	$11,240	6	540
Oxycodone Hydrochloride	Central Nervous System	$10,577	55	5,754
Morphine Sulfate	Central Nervous System	$6,552	16	1,620
Apap/Hydrocodone Bitartrate	Central Nervous System	$6,207	69	5,540
Opana Er	Central Nervous System	$5,724	2	240
Cubicin	Central Nervous System	$4,901	1	24
Apap/Oxycodone	Central Nervous System	$4,650	65	2,617

All Fee-for-Service

Product Name	Therapeutic Class General	Net Pay	Patients	Days Supply
Abilify	Central Nervous System	$8,009,198	2,514	360,590
Synagis	Anti-Infective Agents	$2,774,055	257	34,408
Invega Sustenna	Anti-Infective Agents	$1,954,917	242	45,154
Seroquel Xr	Anti-Infective Agents	$1,825,654	665	107,029
Nexium	Gastrointestinal Drugs	$1,576,555	1,847	290,225
Truvada	Gastrointestinal Drugs	$1,471,660	250	41,510
Spiriva	Autonomic Drugs	$1,255,075	1,577	252,775
Cymbalta	Autonomic Drugs	$1,200,020	1,259	199,740
Invega	Autonomic Drugs	$1,166,649	255	51,967

Prescription Drugs – Top 10 by # of Patients, 2013

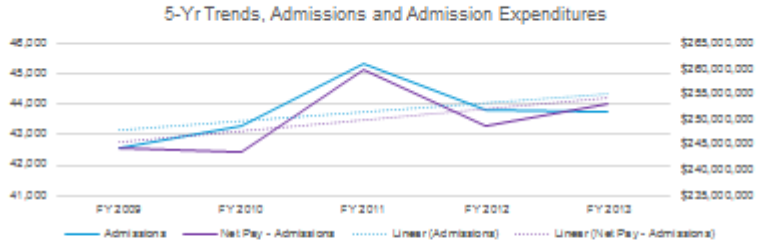
ER Frequent Fliers

Product Name	Therapeutic Class General	Patients
Apap/Hydrocodone Bitartrate	Central Nervous System	69
Apap/Oxycodone	Central Nervous System	65
Azithromycin	Anti-Infective Agents	42
Ciprofloxacin	Anti-Infective Agents	40
Tramadol Hydrochloride	Central Nervous System	38
Gabapentin	Central Nervous System	38
Hydrocodone Bitartrate and Acetaminophen	Central Nervous System	36
Ondansetron	Gastrointestinal Drugs	36
Oxycodone Hydrochloride	Central Nervous System	35

All Fee-for-Service

Product Name	Therapeutic Class General	Patients
Apap/Hydrocodone Bitartrate	Central Nervous System	20060
Amoxicillin	Anti-Infective Agents	18428
Azithromycin	Anti-Infective Agents	14445
Ibuprofen	Central Nervous System	11416
Albuterol Sulfate	Autonomic Drugs	8046
Lisinopril	Cardiovascular Agents	7655
Apap/Oxycodone	Central Nervous System	7455
Cephalexin	Anti-Infective Agents	7474
Alprazolam	Central Nervous System	7045

Admission Trends, Overall, FY 2009 – FY 2013



	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	5-Yr Change
Admits Acute	42,592	43,268	45,367	43,837	43,785	2.8%
Net Pay Admit Acute	$244,413,317	$243,408,288	$259,947,852	$248,608,939	$252,943,241	3.5%

Beth Slamowitz, Pharm.D.: Looking at the acute admits, the number doesn't increase that much, 2.8% over 5 years which is good. That might have some to do with the secondary clinics, the urgent care clinics.

Admission Trends by DRG

DRGs with largest 5-year increases (at least 10 admissions in FY09)

DRG w Code	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	5-Yr Trend
054 Nervous System Neoplasms w MCC	10	19	27	50	50	200%
637 Diabetes w MCC	76	150	169	200	205	170%
955 Non-Extens Burns	12	18	24	18	26	117%
965 Extens Off Proc Unrelated to Prin Dx wo CC/MCC	12	12	15	15	26	117%
071 Nonspecific Cerebrovascular Disorders w CC	12	11	15	14	25	108%
884 Organic Disturbances & Mental Retardation	65	78	106	144	125	105%
133 Other Ear Nose Mouth & Throat OR Procs w CC/MCC	10	16	15	24	20	100%
189 Pulmonary Edema & Resp Failure	172	169	221	261	333	94%
066 Traumatic Stupor & Coma-Coma <1 Hr w CC	10	21	17	21	19	90%
064 Intracranial Hemorrhage or Cerebral Infarction w MCC	96	128	169	166	182	90%

Admission Trends by DRG

DRGs with largest 5-year decreases (at least 10 admissions in FY09)

DRG w Code	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	5-Yr Trend
664 Minor Bladder Procs wo CC/MCC	21	19	8	7	3	-86%
887 Other Mental Disorder Dxs	41	35	28	24	6	-85%
839 Chemo w Acute Leukemia As SDx wo CC/MCC	22	15	42	57	4	-82%
747 Vagina Cervix & Vulva Procs wo CC/MCC	16	15	14	9	4	-75%
497 Local Excis & Remov Int Fix Dev X Hip/Femur wo CC/MCC	12	10	9	5	3	-75%
020 Intracranial Vascular Procs w PDx Hemorrhage w MCC	17	5	6	5	5	-71%
665 Minor Bladder Procs w CC	15	6	12	4	4	-69%
627 Thyroid Parathyroid & Thyroglossal Procs wo CC/MCC	31	11	11	11	10	-65%
714 Transurethral Prostatectomy wo CC/MCC	12	11	10	5	4	-67%
167 Other Resp System OR Procs w CC	25	22	21	16	9	-64%

Members w 9+ Admissions: Population Metrics

- 105 Members
- 48% Male (vs 43% Male for all FFS Medicaid)
- Average age: 42.1 (vs 33.7 for all FFS Medicaid)
- Saw an average of 19 providers (same as ER frequent flier population)
- Patients filled 76 prescriptions on average (same as ER FF population)
- More likely to live in urban Clark County (85% vs 64%)

Coleen Lawrence: We are looking at the fee for service claims. Saying it was Clark County, right there you have a very specific population that we are talking about because in Clark County and in Washoe County, we have what we call "Moms and Babies", and our age, blind and disabled patients. You have a very select population who are not in managed care that are in this group. This was before the Medicaid Expansion.

Members w 9+ Admissions: Admissions by DRG, FY13

Most common DRGs in the high admission population, as % of all admissions

	High Admit Group		All Medicaid		
DRG w Code	Admissions	% of Total	Admissions	% of Total	Ratio
640 Nutritional & Misc Metabolic Disorders w MCC	144	10.4%	459	1.0%	10.5
682 Renal Failure w MCC	72	5.2%	416	1.0%	5.4
812 Red Blood Cell Disorders wo MCC	66	4.8%	345	0.8%	6.0
291 Heart Failure & Shock w MCC	52	3.7%	456	1.0%	3.8
885 Psychoses	43	3.1%	3,134	7.2%	0.4
637 Diabetes w MCC	41	3.0%	205	0.5%	6.3
638 Diabetes w CC	33	2.4%	278	0.6%	5.7
313 Chest Pain	31	2.2%	529	0.8%	3.0
190 Chronic Obstructive Pulmonary Disease w MCC	30	2.2%	444	1.0%	2.1
191 Chronic Obstructive Pulmonary Disease w CC	30	2.2%	521	0.7%	2.9

Avoidable Admissions - Introduction

The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." **These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.**

Even though these indicators are based on hospital inpatient data, they **provide insight into the community health care system or services outside the hospital setting**. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management….

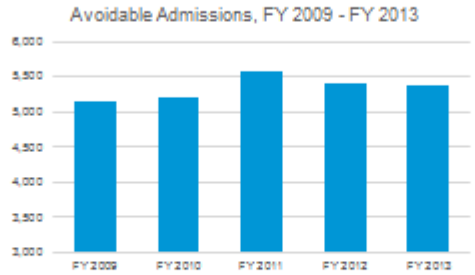
Avoidable Admissions – Introduction (cont.)

With high-quality, community-based primary care, hospitalization for these illnesses often can be avoided. Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community.

They can be used to provide a window into the community — to identify unmet community health care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.

For more information, please see http://www.qualityindicators.ahrq.gov

Avoidable Admission Trends



"Avoidable Admissions" are conditions on admission claims that generally would not have resulted in inpatient admission if appropriate prior treatment had occurred. The conditions included in this subset are angina without procedure, asthma, bacterial pneumonia, CHF, COPD, dehydration, diabetes, hypertension, low birth weight, pediatric gastroenteritis, perforated appendix, and urinary tract infection. Source: AHRQ Prevention Quality Indicators, Version 4.2, September 2010.

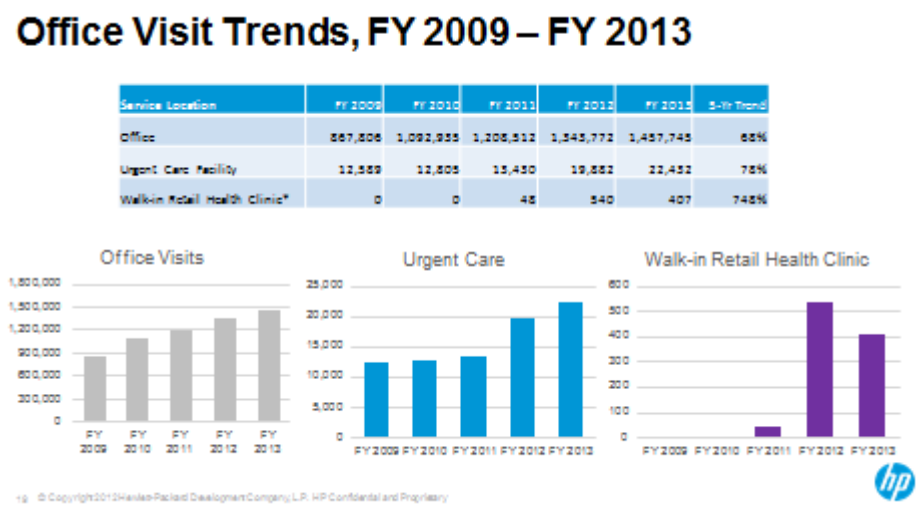
Paul Oesterman, Pharm.D., Chairman: The column on the left, is that patient days or total?
Beth Slamowitz, Pharm.D.: That is total.

Avoidable Admission Trends (cont.)

	Acute Admissions					
Avoidable Admission Condition	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	5-Yr Trend
Diabetes	650	721	911	875	882	36%
Asthma	391	480	447	456	469	20%
Urinary Tract Infection	599	582	629	654	635	7%
Hypertension	140	176	155	147	149	6%
Perforated Appendix	71	73	66	62	75	6%
Bacterial Pneumonia	645	585	966	594	647	0%
Congestive Heart Failure	822	715	817	781	809	-2%
COPD	756	719	769	755	715	-5%
Low Birth Weight	629	647	586	576	596	-5%
Pediatric Gastroenteritis	63	53	50	44	55	-8%
Dehydration	165	124	149	95	109	-33%
Angina without Procedure	52	20	29	24	20	-58%

Considering the growth of the population as a whole, these results indicate that the system is improving its ability to deliver high quality, coordinated care in outpatient settings, preventing complications and increasingly severe disease.

An increase in high quality outpatient care should correspond to a decrease in admissions



Paul Oesterman, Pharm.D., Chairman: Thanks Dr. Slamowitz for the presentation. The Board will review and come back with some ideas and recommendations for the next meeting.

The Board discussed access to health care or lack of using the care that is available. It was suggested to look at more than just ER, but also looking at labs, primary care visits, compliance. Coordination of care and care management were mentioned as possible areas to help.

Paul Oesterman, Pharm.D., Chairman: Requested a report to see something along the lines of how often the ER frequent flyers are using other services including pharmacy.

Dave England, Pharm.D.: Asked how Nevada compares to other programs.

Coleen Lawrence: Stated that Medicaid programs are hard to compare, but New Mexico is close to Nevada and we should be able to get some comparisons.

Paul Oesterman, Pharm.D., Chairman: Also suggested a closer look at asthma and diabetes patients.

4) Clinical Presentations

a) Presentation of sofosbuvir utilization and clinical information

Paul Oesterman, Pharm.D., Chairman: Recuses himself from the discussion due to a financial interest. Dave England, Pharm D. steps in to chair the meeting for this agenda item.

Betty Chan: On behalf of Gilead Science, stated the recommendations are consistent with the label. The only population was not addressed was the HIV/HCV co-infected patients. On our label we do have an indication for the co-infected. The recommendation is the same as the

mono-infected. She recommended adding that indication under number 1, “the following guidelines apply to HCV mono-infected and HCV/HIV co-infected with HIV”.

CarlJeffery, Pharm.D.: Presented clinical information and utilization trends.

Members discussed the treatment guidelines and goals of the PA criteria.

Carl Jeffery, Pharm.D.: Requetsed the Board to add a quantity limit of 12 weeks of therapy at a time limit. Also adding a letter “E” to the criteria for the co-infected patients.

Dave England, Pharm.D.: Proposed to accept the presented criteria as-is, with the addition of “E” that talks about the HIV co-infected and then changes on the quantity of 12-week intervals based on genotype.

James Marx, MD: I so move.
Jeff Zollinger, DO: Second.
Board votes unanimous “Aye.”

Paul Osterman, Pharm.D. returned to Chair the meeting.

b) Presentation of Hepatitis C Protease Inhibitors utilization and clinical information

Mary Kay Queener: Of Johnson and Johnson stated the PA criteria largely matched the package insert. She requested two changes. Under treatment continuation for weeks 9 through 12, the criteria calls out treatment naïve and prior relapsers, but in the package insert, prior-partial and null-responders are also included. She recommended adding those in as well or maybe just not have the particular sub-types called out. She also recommended under number one for treatment initiation, adding pre-screening the patients who have genotype 1A for the NS3 Q80K polymorphism because there is significantly decreased efficacy if they have this polymorphism.

Carl Jeffery, Pharm.D.: Preseented clinical information and utilization trends.

Members discussed the duration of therapy and quantity limits.

Paul Oesterman, Pharm.D., Chairman: Suggested the addition of the Olysio product to the current class. He called for approval of the revised criteria to include the addition of a 1. D. patients must NOT have NS3 Q80K polymorphism prescreening. And add E to include null-responders and prior-partial responders.

Dave England, Pharm.D.: So moved.

James Marx, MD: Second.

Board votes unanimous, “Aye.”

c) Presentation of palivizumab utilization and clinical information

Public Comment: None.

Carl Jeffery, Pharm.D.: Presented clinical information, utilization statistics and current criteria. He stated the current criteria was not quite aligned with the guidelines. In letter B, the new guidelines state the age should be 28 weeks and 6 days instead of just 28 weeks of gestation. So that adds that time to align with the guidelines. The other change is adding that the recipient is under the age of two at the start of the RSV season. As it is now, if they turn 2 during the season, they technically don't qualify any more.

Board members discussed by Board about RSV season definition.

Paul Oesterman,Pharm.D., Chairman: Proposed a motion to approve the revised criteria for Synagis.

Dave England, Pharm.D.: So moved.
James Marx, MD: Second.
Board votes unanimously, "Aye."

d) Presentation of proton pump inhibitor use and clinical information

Public Comment: None.

Carl Jeffery, Pharm.D.: Presented a brief clinical background, utilization and the current PA criteria. He suggested loosening the criteria to make them more accessible, and adding quantity limits of one per day.

The Board discussed quantity limits and concomitant use with other similar agents.

Paul Oesterman, Pharm.D., Chairman: Proposed a motion to approve the revised proposed criteria to include three steps with an "or" between each and the first two steps as presented and the third with the criteria of concurrent therapy with a PPI with an H2 antagonist or sucralfate.

Dave England, Pharm.D.: So moved.

James Marx, MD: Second.

Board votes unanimously, "Aye."

e) Presentation of immunomodulators use and clinical information

Sandy Sierawsky: with Pfizer, spoke on Xeljanz. She provided details on the mechanism of action, indications, administration, and contraindications. She pointed out the title on the criteria is "Injectable" but Xeljanz is an oral product.

Mary Kay Queener: with Johnson and Johnson, provided information regarding Stelara and the new indications for psoriatic arthritis and pediatric Crohn's and pediatric ulcerative colitis.

The members of the Board discussed how best to list the different drugs for the treatment with the different indications. The rules and exceptions for the decision process were discussed.

Paul Oesterman, Pharm.D., Chairman: Suggested the following changes to the criteria: remove the word, "Injectable", remove the specific brand names associated with each of the conditions, and then the next time we will bring back the criteria to include pediatric Crohn's and pediatric UC.

Dave England, Pharm.D.: So moved.

James Marx, MD: Second.

Board votes unanimously, "Aye."

f) Presentation of products used to treat ADD/ADHD use and clinical information

Sandy Sierawsky: with Pfizer. talked about Quilivant XR. She identifies when it is prescribed by a psychiatrist, the criteria is less restrictive. She provided data from IMS Health regarding prescribing trends of long-acting stimulants, few written by psychiatrist, the rest from other practitioners. The ADA requires that pediatricians diagnosis and treat ADHD, from the Academy of Pediatrics. She stated the current criteria are cumbersome and restrictive and requests removing some barriers.

The Board discussed removing reference to DSM-IV and specific codes for ICD-9 and ICD-10, and the benefits and drawbacks of having it listed in Chapter 1200. The diagnosis still needs to be documented on the prescription and the prescriber still needs to call for a PA. The history of the criteria for psychiatrist override was also discussed.

Utilization statistics, and the increase in use was discussed The top prescribers are still psychiatrists. Regarding the concomitant use of short-acting and long-acting, are they being used together or diverted.

Paul Oesterman, Pharm.D., Chairman: Proposed to eliminate DSM-IV terminology, and leave as "Diagnosis of ADHD/ADD" and bring back the criteria for the next meeting with some specific patient data as to what kind of product, duration of therapy, and quantities used.

Dave England, Pharm.D.: Motion to accept the Chairman's proposal.
Jeff Zollinger, DO: Second.
Board votes unanimous, "Aye."

g) Review of transdermal fentanyl use and clinical information

Public Comment: None.

Carl Jeffery, Pharm.D.: Gave background information on why this drug is being reviewed. It has been five years since the last review and a generic is now available.

Utilization was discussed. The lower strengths use is increasing more than the other strengths. The appropriate utilization of 12mcg patch vs. the 25 mcg patch and when they should be started was discussed. Dr. Marx was surprised to see the utilization is so low. Problems of adhering to skin for 72 hours and skin reactions are reasons it may not be used as much..

Paul Oesterman, Pharm.D., Chairman: requested a report for the amount of fentanyl by age and diagnosis.

James Marx, MD: Suggested maybe having an edit to add a step of using fentanyl transdermal before moving to short acting and morphine.

Options for PAs were discussed. Quantity limits exceeding beyond 15 per 30 day, will require justification. The current quantity limit is one patch every 3 days.

A proposal was made to amend the current criteria to add a quantity of 15 per month, beyond that would require a PA.

Continued discussion on adding the criteria supported by the Black Box Warning. And calculating a morphine equivalent dose before approval is discussed.

Paul Oesterman, Pharm.D., Chairman: suggested changing A to "patient failed lesser means such as acetaminophen/opioid combination".

He stated that fentanyl patches are often used in combination with short-acting and other long-acting opioids.

Jeff Zollinger, DO: Recommended adding a statement of, "Not intended for the opioid naïve patient".

The item was tabled until the next meeting with a report on utilization by age and diagnosis.

h) Presentation of botulinum toxin products use and clinical information

Public Comment:

Deirdre Monroe with Allergan, agreed with the proposed language added to the policy.

Coleen Lawrence: Updated the Board about the policy added to chapter 600. It will be going to the June public hearing. One more statement that physicians must document utilization is for an FDA approved indication will be added. Physician Services billing manual will be updated at the same time.

Botulinum toxin will be limited to be dispensed by physician's offic's only.

No action taken.

i) Presentation of buprenorphine and buprenorphine/naloxone use and clinical information

Public comment: None.

Discussion by members on updating the criteria to include the new products available. Quantity limits were also updated. A reference to the drug names was removed. Options of adding Methadone transition as a reason for getting the buprenorphine-only product was discussed.

Paul Oesterman, Pharm.D., Chairman: requested a report of the count of recipients, the count of claims of top 25 recipients, how many recipients are started and never refilled or recipients on it indefinitely. He proposed a motion to approve the prior authorization criteria as previously amended with counseling recommended.

Dave England, Pharm.D.: Moved.
James Marx, MD: Second.
Board votes unanimous, "Aye."

j) Presentation of Hydrocodone ER (Zohydro®) use and clinical information

Public Comment: None.

Carl Jeffery, Pharm.D.: Presented indications, the approval process through FDA, and the process for obtaining this medication.

Board members discussed utilization. No usage since it was introduced. PA options and quantity limits was also discussed.

A motion was made to add a quantity limit of 5 tablets per 30 days for Zohydro ER. No PA criteria to exceed the quantity limit.

Dave England, Pharm.D.: Moved.

Jeff Zollinger, DO: Second.

Board votes unanimous, "Aye."

5) DUR Board Requested Reports

a) Special Presentation: Clinical Steering Board Presentation

Presented earlier in meeting

b) Report on Top 10 Black Box warning medications:

Not provided, tabled for next meeting.

c) Report on Controlled Substance utilization and trends

Presentation and discussion of utilization.

Paul Oesterman, Pharm.D., Chairman: Asked if it is reasonable to have the pharmacy check the controlled substances task force database before dispensing any controlled substances..

It was requested to add an agenda item for next meeting to have a Board of Pharmacy representative come talk to the DUR Board.

d) Report on psychotropic drug use in children

Carl Jeffery, PharmD. presented the utilization by age of psychotropic drugs, physician office claims and POS claims. The history of adding the PA criteria for the kids was discussed.

Paul Oesterman, Pharm.D., Chairman: Requested pulling out the seizure disorder diagnosis and bringing the data back to the next meeting.

Dave England, Pharm.D.: Requested comparing which are prescribed by a psychiatrist vs. family practitioners.

Action for next meeting: Remove Seizure related diagnosis, break down by provider specialty type and remove PAD claims.

e) Report on Promethazine VC use

Carl Jeffery, PharmD: presented the utilization of Promethazine VC.

The Board discussed the utilization.

Paul Oesterman, Pharm.D., Chairman: Proposed implementing the same quantity limits imposed on Promethazine with codeine, 120ml per fill up to 3 fills per rolling 365 days with 30 days of messaging before turning the hard stop on.

Dave England, Pharm.D.: Moved.

James Marx, MD: Second.

Board votes unanimous, “Aye.”

f) Report on Blood Factor Product utilization

Carl Jeffery, PharmD: presented the utilization data on blood factor products.

The Board discussed of utilization of all outpatient claims.

g) Report on Abilify utilization by age and diagnosis

Carl Jeffery presented the of utilization of Abilify.

The Board members discussed the utilization.

Paul Oesterman, Pharm.D., Chairman: Proposed requiring a diagnosis on the POS claim on all antipsychotic medications for children.

Dave England, Pharm.D.: Moved. All Abilify claims need to have a diagnosis submitted on the claim, no edit on what the diagnosis is, for all ages.

James Marx, MD: Second.

Board votes unanimous, “Aye”

h) Report on ProDUR edit on late refill

Presentation and discussion on ProDUR edits.

Paul Oesterman, Pharm.D., Chairman: Requested a report showing the correlation between ER visits and late refills.

i) Report on seizure medication utilization and patient compliance

Presentation and discussion of messages returned to pharmacy.

6) Standard DUR Reports

Presented DUR reports. Brief discussion of Medicaid enrollment expansion.

a) Review of Prescribing/Program Trends
   i) Program Trends
   ii) Top 10 Therapeutic Classes for Q3 2013, Q4 2013, and Q1 2014 (by Payment and by Claims)
   iii) Top 50 Drugs of Q3 2013, Q4 2013, and Q1 2014 (by Payment and by Claims)

b) Concurrent Drug Utilization Review (ProDUR)
   i) Review of Q3 2013, Q4 2013, and Q1 2014
   ii) Review of Top Encounters by Problem Type

c) Retrospective Drug Utilization Review (RetroDUR)
   i) Public Comment
   ii) Review of Responses
   iii) Status of Previous Quarter
   iv) Status of Current Quarter
   v) **For Possible Action**: Board Discussion and Approval of Future Criteria Selection

7) Closing Discussion

a) Public Comment

None.

b) Date and Location of next meeting

July 24, 2014 at 5:30 at the Best Western.

c) Adjournment

Meeting Adjourned at 8:56 PM.