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MEDICAID
DRUG USE REVIEW BOARD
MEETING MINUTES

Date of Meeting:	**Thursday, January 26, 2017 at 5:15 PM**
Name of Organization:	**The State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP), Drug Use Review Board (DUR).**
Place of Meeting:	**Best Western Plus Airport Plaza Hotel** **1981 Terminal Way** **Reno, NV 89502** **Phone: (775) 348-6370**

Committee Members Present: James Marx, MD; Paul Oesterman, Pharm.D.; Chris Shea, Pharm.D.; David England, Pharm.D

Committee Members Absent: Michael Owens, MD; Jeffrey Zollinger, DO

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

HPES: Beth Slamowitz, Pharm.D.

OptumRx: Carl Jeffery, Pharm.D.

Others: Krystal Joy, Otsuka; Betty Chan, Gilead; James Kotusky, Gilead; Sandy Sierawski, Pfizer; John DiMuro, MD

Others On-line: Mark Reynolds; Julayna Meyer, Envolve Health; Georgette Dzwilewski, Indivior; Chris Standfield; Michael Faithe, Amgen; Dr. Shirley Linzy; Jeanette Belz; Ann Nelson; Jeannine Murray, Anthem; Altamit Lewis, Amerigroup

1. Call to Order and Roll Call

Call to order: 5:22 PM

Paul Oesterman, Chair: We will go ahead and call the meeting of the Drug Use Review Board to order. Our first meeting of 2017. I will start with roll call on my far left.

Carl Jeffery, OptumRx

James Marx, Physician, Las Vegas

Dave England, Pharmacist, Las Vegas

Chris Shea, Pharmacist, Reno

Paul Oesterman, Chair, Pharmacist, Reno

Darrell Faircloth, Senior Deputy Attorney General's Office

Shannon Sprout, Chief, Policy Development and Program Management

Mary Griffith, Social Services Program Specialist

2. Public Comment on Any Matter on the Agenda

3. Administrative

a. **For Possible Action:** Review and Approve Meeting Minutes from October 27, 2016.

Paul Oesterman, Chair: We have a quorum. I will start by asking for public comment on any item on the agenda. We have some people that have called in, so we will ask for their comment now. Seeing no comment. We will go to the administrative part of the agenda. The first is review and approval of the October meeting minutes. I will ask the Board to review the minutes.

James Marx: I move for approval.

Chris Shea: Second.

Paul Oesterman, Chair: Any further discussion?

Voting: Ayes across the board, the motion carries.

b. Status Update by DHCFP

Paul Oesterman, Chair: Our second administrative item is the status update from the Department and any Chapter 1200 changes.

Mary Griffith: This is Mary Griffith. The legislative session is starting February 6th. It is looking like it will be a very active one. Regarding the policy that was approved by the DUR Board last October, for the initial 7 day limit on opioid prescriptions, we anticipate that to be implemented after the April 26, 2017 public hearing, so we think it will be the following day on April 27, 2017.

Paul Oesterman, Chair: That is the tentative next DUR Board meeting.

Mary Griffith: I think that is right. That should be implemented the next day. I don't anticipate any problems with that. It is just getting everything ready for the public meeting. We do have another pharmacy person, Heather Labonte, she wasn't able to attend today. She will be able to help out with the pharmacy items going forward. That is all I have for updates.

4. Board Actions

a. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for all prescription drugs for Hospice Program recipients.

Paul Oesterman, Chair: We will start with the Board actions. The first is the discussion and possible adoption of updated prior authorization criteria for all prescription drugs for Hospice Program recipients.

Do we have any comment from the public? Seeing none, lets looks at the revised criteria.

Carl Jeffery: The sheet you have is separate from the binder, is the most recent we have. Right now the criteria is for members only over 21 years old. We talked about including the under 21 population, but the way it was on the agenda, we were stuck with just over 21. Look at the trends in your binder starting on page 27. You can see a significant drop off on page 28 of when we implemented this last month in December. Requiring a prior authorization has drastically reduced the number of claims we were seeing. Before, a pharmacy could enter an override code without a PA. The hospice agencies were making the call on what they will cover. I haven't heard any complaints about it. We wanted to see about rolling it out to kids as well. There are some restrictions with the under 21 members, where we still have to provide medications pursuant to the Affordable Care Act, and EPSDT.

Mary Griffith: Typically members on hospice waive their right to any curative treatment. But because of children, the ACA and the SSA says we cannot restrict children under the age of 21 from being on hospice and seeking curative treatment. So we have that caveat for children under the age of 21. The other consideration is that it isn't that Medicaid won't pay for this treatment, it is just saying that hospice should be paying. We are not denying services.

Dave England: You are saying, if they are under 21 there is no hospice?

Mary Griffith: If they are under 21, they can get palliative care and a curative treatment. If they needed chemotherapy, they could still get that paid by Medicaid, but anything palliative like pain

medications would be covered by hospice. We found we were way over paying for drugs for palliative treatments, so we have to do this to get a handle on it.

Paul Oesterman, Chair: I think the evidence is the significant reduction in the over 21 members.

Mary Griffith: The over 21 went up, and the under 21 went down, so hopefully we will get a handle on it for next time.

Paul Oesterman, Chair: We have the updated proposed guidelines for both age groups. We need a motion and second.

Dave England: So moved.

James Marx: Second.

Voting: Ayes across the board, the motion carries.

b. **For Possible Action:** Discussion and possible adoption of updated criteria for the Controlled Substance Pharmacy Lock-In program.

Paul Oesterman, Chair: Our second Board action includes the discussion and possible adoption of updated criteria for the controlled substance pharmacy lock-in program. Is there any public comment on this topic?

Seeing none in the room or on line.

Mary Griffith: Originally we put it on for a reason, then we found out we should just leave it as is. By that time it was too late to change the agenda. But we left it on for general comment. Currently we have about 1000 people on lock-in. They're put on for drug seeking behavior, we could have many more, but we have to devote more time to it. Maybe with the new person in the office, we can get some more help with it. There are several more people that we could have on this program. We keep them on indefinitely.

James Marx: How do these members get filtered? I have two members that are on it, and neither meet this criteria.

Mary Griffith: They must have met it in the past, we are looking at ER visits and number of prescriptions in 60 days. We are looking for 10 or more within 60 days. That includes ER visits. But they are also looking for diagnosis. If they have a diagnosis of addiction, that is a red flag. We have a nurse that reviews this list of people every month. They also look at diagnosis.

James Marx: Does it look at just controlled substances or all drugs?

Carl Jeffery: Just controlled substances.

Paul Oesterman, Chair: I would like to see something added to be able to take people off the list. It might lighten the load and be able to include other patients.

Mary Griffith: Right, there is some hesitation. People that have addiction will have that forever, but there are some people that could come off. We just haven't figured out the right way.

Carl Jeffery: We have talked about this before. There was a big push to get some behavior therapy and treatment as well for people with addiction.

James Marx: These patients were not addiction patients. I don't know how that criteria was met. They don't use emergency rooms. They may have 10 controlled substances in 60 days.

Mary Griffith: They don't have to meet all of them.

Shannon Sprout: In general, if you find something that is outside of the written policy, you can reach out to Mary and we can look at those recipients. There may be something coming from claims that you have not seen. But we can look at these if you can send the member details.

James Marx: Generally it isn't a problem, but there was one patient the pharmacy that refused to order medications. They changed pharmacies and things are better now. The other patient died. It has never really been a problem, just more of an enigma of why they are locked in.

Mary Griffith: We don't want someone with chronic conditions, we look at other reasons why they may need so much medication. It isn't a perfect system. If there is someone that shouldn't be on, we can take a look. What we have found is that that is more of the exception than the rule.

James Marx: I think it is a good program, I just want to make sure we are using it appropriately.

Mary Griffith: We send letters to the doctors too so they are aware.

Dave England: If you look at E, section 1, D – The recipient has been diagnosed with drug dependence addiction. It seems even if they didn't meet the other criteria, this alone would be enough to lock them in. The initial event is 10 scripts, but what if it was 8 or 9, but they have drug dependency and the prescriber is trying to keep them under control, the patient could fall through the cracks. I think we may want to look at a lower criteria. Using "or" instead of "and" criteria. I think we may be missing some that should probably be locked in.

Mary Griffith: We can change how we filter the people to get them on the list. We also look at other behaviors and diagnosis.

Dave England: Looking at line number 3 on page 32 in our handout, recipients can change the lock-in pharmacy at any time by contacting the district office. Can the physician make the call to Medicaid to request a change of pharmacy?

James Marx: There are some conditions that allow a pharmacy to request an override. But they have to know to do that and there are some pharmacies that don't know about it.

Paul Oesterman, Chair: I think we are talking two different things. Dr. Marx I think you are talking about a onetime exception, Dave, I think you are talking about a permanent change.

James Marx: The problem is these issues happen on weekends and holidays. The district office has to be open and answering the phone, so there are some conditions that need to be met.

Dave England: Can we change it to recipients or providers can make the change to the lock-in pharmacy. The provider can arrange the pharmacy for the recipient instead of just the recipient.

Mary Griffith: Typically it is the recipient because they choose which pharmacy to change to. As long as the recipient is aware that the pharmacy is going to change, it shouldn't matter where it comes from.

Beth Slamowitz: Either way, it is going to have to come through Medicaid for the change.

James Marx: Could there be some way to notify the recipient they have the ability for an override?

Mary Griffith: Is it on the NOD?

Carl Jeffery: Yes, I think it is on the Notice of Decision.

Paul Oesterman, Chair: What I'm hearing at this point is a recommendation or comment on point number 1, instead of "if" we have an "or" for each of these criteria. Also the second provision would be for number 3, the recipients that are locked in to one pharmacy can change by contacting the district office or the provider can contact the district office. Does that cover what we discussed?

Dave England: Yes that covers what I was talking about.

Carl Jeffery: By provider, do you mean prescriber and pharmacy?

Paul Oesterman, Chair: I would leave it open to both pharmacy and prescriber.

Dave England: That would allow a pharmacy to change the member if they are having trouble.

Mary Griffith: Would that work systematically?

Carl Jeffery: The change is coming from the case workers, so nothing is going to change from our side. We will still get the change form.

Mary Griffith: But on weekends, the district office isn't open.

Beth Slamowitz: If it doesn't make a difference, it still has to come through Medicaid to make the change regardless of who is making the request.

Dave England: I'm not worrying just about nights and weekends.

Beth Slamowitz: During regular business hours to open to the pharmacy and prescriber to request the request is fine.

Dave England: But we should at least give them the option to do that. If it is an emergency situation, they can get an emergency override, the patient should not be without.

Mary Griffith: If the pharmacy is out of stock or the member is out of town are some exceptions to the lock-in requirement. We also have the 96 hour emergency override.

Dave England: The provider has the option to have them go somewhere else.

Beth Slamowitz: Does the 96-hour override work if they are locked in?

Carl Jeffery: The call center can enter overrides if the pharmacy is out of stock.

Mary Griffith: It would be the same situation if the pharmacy is closed, they would still call the call center for the 96 hour override, so it is the same thing.

Carl Jeffery: For the case workers, do they need authorization from the recipient for the provider to work on the recipient's behalf?

Beth Slamowitz: Like a release?

James Marx: I don't think you would have any objection from the recipient. I think another thing coming up with the DEA reduced allocation, this is the first month, after the 25th there may be some shortages all over the place. That will be another can of worms.

Paul Oesterman, Chair: I tried to order some morphine today and they told me my allocation was up. I called and got an override.

Chris Shea: For the 96 hour override, how does the pharmacy know if another pharmacy could help them? Is there an override code they can transmit?

Carl Jeffery: They have to call the call center.

Chris Shea: I asked someone if we accepted a lock-in recipient into a nursing home, we will get a rejection. She said it can take a couple days to get payment and a lot of times the facilities will pay for it until we can get it done. It doesn't sound like the pharmacies are getting a response about who to call for a change.

Carl Jeffery: The override would be immediate if they call.

Paul Oesterman, Chair: To recap, we have proposed revision to the lock-in criteria where we are adding the "or" to points for number 1, and number 3 we will include the provider has the ability to contact the district office to change the pharmacy.

James Marx: Can the call center initiate the request? It is much easier getting the call center than the district office.

Beth Slamowitz: The call center can add a onetime override, where the district office would still need to make the change.

James Marx: I'm not sure we are going to spend the time calling the district office.

Mary Griffith: Is it possible to change the messaging that goes to the pharmacy where they can get a message to call the call center for an override? The pharmacy would be more aware of the options.

Carl Jeffery: I would have to look to see what the message is now, but we can customize the message.

Paul Oesterman, Chair: We need a motion and second to approve the revised policy in regards to lock-in.

James Marx: Was there no formal procedure?

Paul Oesterman, Chair: I think we changed the "if"s to the "or"s and added the provider to change the pharmacy.

Dave England: It is more inclusive and can be changed by various methods.

James Marx: Ok.

Dave England: So moved.

James Marx: Second.

Voting: Ayes across the board, the motion carries.

5. Clinical Presentations

a. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for the medication class Incretin Mimetics.

Paul Oesterman, Chair: We are moving into our clinical presentations. If people wish to speak, there is a limit of five minutes. The first is the discussion and possible adoption of updated prior authorization criteria and/or quantity limits for the medication class incretin mimetics. Do we have any public comment from the audience?

Hearing none, we will go ahead and look at the proposed criteria.

Carl Jeffery: We have criteria for this class already, but it only includes Bydureon, Byetta and Victoza. There are a couple new agents in the class and some approved but not available yet. The criteria is the same, we just added the new products and updated the quantity limits. The P&T just voted to make all the available products as preferred. Right now a member can get Tanzeum or Trulicity without any restriction. These are pretty mainstream medications, should they still require prior authorization? Could the Board consider removing the PA criteria?

Paul Oesterman, Chair: With the number of co-morbid complications we see with our diabetic population, anything we can do to enhance the patient's access to their medications would be beneficial. I like the idea of removing the criteria completely.

Dave England: Would there be a possibility of having two different agents?

Carl Jeffery: The DUR and pharmacies should catch that.

Dave England: Otherwise, it is part of the treatment, insulin and metformin just don't cut it any more. As long as it is in the mix, that is one less call to make.

Paul Oesterman, Chair: This is standard of care now.

Darrell Faircloth: Did the P&T add any criteria for those that are preferred?

Carl Jeffery: No, the P&T doesn't add any criteria, they just decide what is preferred and non-preferred. They have some authority to add tweaks here and there. But they don't add clinical criteria.

Shannon Sprout: They send that information back to the DUR Board to evaluate the PA criteria.

Dave England: If this is part of the treatment criteria and includes best-practices, and the DUR criteria catches a duplicate, I could see dropping the PA.

Carl Jeffery: The Victoza has a sister drug indicated for weight loss, so maybe requiring a diagnosis related to diabetes, that way you wouldn't get these used for weight loss.

Chris Shea: Patients like Byetta because they lose a lot of weight on it. I could see some weight loss clinics writing for this.

Dave England: Do we want to leave the PA criteria to limit for diabetes?

Carl Jeffery: You could use any of them for weight loss.

Dave England: The PA would validate for diabetes and not for weight loss.

Beth Slamowitz: If you wanted to remove the PA, you could still require a diagnosis submitted on the claim.

Carl Jeffery: On the proposed criteria, it would remove number 3, the step for metformin or sulfonylurea. You're essentially removing that and adding criteria to submit the code.

Paul Oesterman, Chair: That would be better.

Beth Slamowitz: You're saying still have the PA and just submit the forms, but you would still have to do it through a PA. It might be a little easier for the pharmacy to submit the diagnosis.

Carl Jeffery: From the system standpoint, it would still deny for PA if for some reason there was no diagnosis on the claim.

Chris Shea: It kicks that back and says it is missing a diagnosis.

Carl Jeffery: The doctor would still need a PA if they didn't write the diagnosis on the prescription.

Paul Oesterman, Chair: It looks like we want to remove the prior authorization process for the incretin mimetics, but the prescription would require a diagnosis code of type two diabetes. Do we have a motion to remove the incretin mimetic prior authorization process as it currently stands?

Dave England: So moved**.**

James Marx: Second**.**

Voting: Ayes across the board, the motion carries.

b. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for Lumacaftor-Ivacaftor (Orkambi®).

Paul Oesterman, Chair: The second possible action is the discussion and possible adoption of updated prior authorization criteria for Lumacaftor-Ivacaftor, Orkambi. Do we have any public comment?

Seeing none, we will go ahead and review the revised criteria.

Carl Jeffery: This is easy**.** They have an indication down to six years old from 12.

Paul Oesterman, Chair: The use looks pretty consistent, about four claims per month. I think this is straight forward. Do we have a motion and a second?

Dave England: So moved**.**

Chris Shea: Second**.**

Voting: Ayes across the board, the motion carries.

c. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for medications used for the treatment of opioid dependence.

Paul Oesterman, Chair: The next item is the discussion and possible adoption of updated prior authorization criteria for buprenorphine/naloxone and buprenorphine. We have one person here to speak.

John DiMuro: Good afternoon, I'm Doctor John DiMuro, I'm the Chief Medical Officer for the State of Nevada and I have been working with the senior behavior mental health policy person and Stephanie Woodard as well with Shannon and Mary with DHCFP. A significant barrier to treatment with these patients with substance abuse is the ability to get the Suboxone or buprenorphine to them right away. I feel we need to allow physicians to prescribe these drugs and have the drugs up to 7 days for the patient at the time they are prescribed in the event we are unable to get a prior authorization. We see this is a huge barrier to getting patient treatment

immediately and if they don't have the drug right away, they are more apt to not take the drug. After working with Shannon and Mary and Dr. Woodard, we feel this is a significant issue we would like the Board to take into account and allow physicians to prescribe and the prescriptions filled without the prior authorization for up to 7 days. I prefer seven days over three, it looks like Dr. Marx is the only prescriber here, I'm dual board certified in anesthesiology and pain medicine. Always on Thursday and Friday patients will have issues with their medications. That will also be the time they are considering moving to a buprenorphine drug. If this happens before a holiday, a three day window would not work. So Shannon, Mary, myself and Dr. Woodward feel seven days would be appropriate. We all agree a seven day window would best benefit the patients.

Paul Oesterman, Chair: Does anyone on the Board have questions?

James Marx: As a Suboxone prescriber and addiction specialist, I would take no exception to seven days, the 72 hour override has worked out fairly well in the past. Some of the manufacturers supply a 15 pill pack and for most that is enough for 3 to 5 days and that is usually enough to get a PA in. I think the seven day is quite reasonable. The problem we see frequently is patients come from acute detox without any prescription for buprenorphine or given an appointment for ten days. I think it is a great idea.

Paul Oesterman, Chair: We do have the proposed criteria with the initial seven day supply. Carl, do you want to recap?

Carl Jeffery: I wasn't at the public hearing a few weeks ago where this was discussed?

Mary Griffith: There was not a lot of people there because of the snow storm.

Carl Jeffery: We met with Dr. DiMuro to refine a seven day supply recommendation. Essentially how the process works is: a patient new to therapy would present the prescription to the pharmacy, it would reject initially, but give a message to use an override code from the pharmacy to allow the seven day fill. There is no phone call involved or anything, the pharmacy gets a paid claim for seven days. It is also the understanding that the pharmacy is responsible to follow up with the prescriber to get the PA submitted. That is part of the criteria too. But this allows an immediate seven day supply to start therapy right away. The rest of the criteria has not changed.

Paul Oesterman, Chair: With these patients, they go off treatment and then want to restart. If you have a PA on file that has elapsed, but now they come to request another seven days, how will that be addressed?

John DiMuro: What we discussed in order to make a Suboxone naïve patient, is if the patient goes seven days without taking the medication, that would make them a naïve patient again. Dr. Marx, I'm not sure if you have any input.

James Marx: I think that is reasonable. I'm not sure any amount of time is reasonable.

John DiMuro: This is important for us to define what a new prescription would be.

James Marx: Usually the lapse would not be that short of a period of time, it is usually several months or years. I don't think it is very likely you are going to see someone lapse for one week.

Beth Slamowitz: To clarify, from a system perspective, once the prior authorization goes into the system, it is good for a year, regardless of how much of a lapse, they could come back six months later and get the medication again. It would only be after the PA has expired.

Paul Oesterman, Chair: Ok, good, that is what I was looking for. Thank you. We have the proposed criteria for the initial seven day supply, the pharmacy submits the PA type and number. Having not worked retail, are most prescriptions for this coming into the pharmacy with an ICD code on it?

Carl Jeffery: I'm not sure.

James Marx: We will write for pain if not for an indication of opioid dependence. This brings up criteria number three. We had a member on Belbuca, he was a pain patient, and he actually preferred Suboxone to oxycodone. He lost his job and was given Medicaid. We wanted to continue Suboxone, but it wasn't allowed because it was being used for pain. He was on 900mcg of Belbuca instead, but the Suboxone was denied. Belbuca has no contraindication to concurrent use of conventional opioid agonists for breakthrough pain, but the Suboxone does. We have other treatments with buprenorphine that are effective for the treatment of pain.

Mary Griffith: So you're saying it is not FDA indicated for pain?

James Marx: Buprenorphine is approved for pain, but not the Suboxone, the Belbuca is. It is a little ironic that we have two opposing philosophies here. One that is more cost effective than the other. There are some other positive features as well, even though there is a diversion potential for Suboxone. It has become a popular drug, particularly in correctional institutions. I think this has become very complex.

Paul Oesterman, Chair: We have the proposed criteria, the prior auth would still be for a year, and the initial seven days would be authorized. Do we have a motion?

James Marx: What would be the impact of deleting criteria number 3, the diagnosis of chronic pain will not be approved. This would allow the use for chronic pain.

Beth Slamowitz: Suboxone would have to have an FDA approved indication for pain in order for Medicaid to pay for it.

Carl Jeffery: The Belbuca is not normally included in this class. It is buprenorphine, but it is not included in this category.

Dave England: If this is needed to be used for pain, could the physician go through the call center to get it approved for something off-label? We have discussed this in the past, as long as there is some documentation.

James Marx: If the doctor wants to, they can bend the criteria. For someone with pain, you could make the case they are opioid dependent. I have to say I have done that once or twice.

Beth Slamowitz: You said you have some patients you use to treat pain and on short acting for breakthrough. The system may catch that.

James Marx: It doesn't and it didn't.

John DiMuro: I agree that Suboxone can be used for pain. My experience is that patients will use Suboxone for pain, and still take other opioids. I would support a rule that would be by the book. Suboxone is not indicated for pain. I think if we are going to make a rule, then we should stick with what is FDA approved.

Paul Oesterman, Chair: Do we have a motion to approve the updated criteria for buprenorphine and combo products.

James Marx: So moved.

Dave England: Second.

Voting: Ayes across the board, the motion carries.

6. Public Comment on any DUR Board Requested Report

7. DUR Board Requested Reports

Paul Oesterman, Chair: At this point, is there any public comment on the DUR Board requested reports? Seeing none. The first report is the detailed utilization of the top utilizers of opioids. Carl can you explain this report?

Carl Jeffery: This is a carryover from the last meeting. We had a list of top utilizing members for opioids. The Board requested a drill down into that data so we can see what those members are using. I did as much as I could without disclosing any HIPPA data. The encrypted ID is A through J.

Paul Oesterman, Chair: The encrypted ID is the member, and they are letters.

Carl Jeffery: The prescribers are defined with a number, one through 23. This is where it gets confusing because it is not the number of prescribers. It is an identifier. Patient C, has 6 different prescribers. That is how those numbers are used. There was a patient that was on large amounts of methadone. We wanted to see what else they were getting. The column is count of date of fill, I can't list the actual date of fill because that may give a clue who the member is. This is a 13 month period. Patient A, hydromorphone, they had 26 fills in 13 months. Sum of the quantity is how many units they have received, the sum of days supply and sum of pharmacy paid.

Paul Oesterman, Chair: Let's look at number A, hydromorphone has 715 total days supply.

Carl Jeffery: It combines different strengths. So if they were on two different strengths, it is the same with the hydrocodone/acetaminophen. You would have to break it down even more to see the different strengths.

Paul Oesterman, Chair: It would be interesting to see if any of these patients are in the lock-in program.

Carl Jeffery: My intent with the prescriber numbers is to compare prescribers across patients. G. is the one with huge amounts of methadone, almost 3800 units of methadone.

Paul Oesterman, Chair: It would be interesting, this report is based on initial slice of patients, it would be interesting to see the top 10 prescribers the next time.

Carl Jeffery: We have looked at prescribers before. We can look at that again.

Chris Shea: Is this cross referenced to the PMP?

Carl Jeffery: I don't have access to the PMP, but it might be interesting to see what else these members are getting.

Paul Oesterman, Chair: A possible action item for next time would be to request further evaluation or propose criteria. At this point, I don't see any criteria we could implement, other than looking at the lock-in for these recipients.

Carl Jeffery: We can pull out the lock-in people to see. These members could also be in lock-in. They just go to one pharmacy.

Paul Oesterman, Chair: On patient C, a fair number of products were filled only once or twice. The oxycodone seems to be consistent. There are 13 fills from two different providers. That seems to be a red flag. We need a motion to request further reports to get the top ten prescribers for next time.

Mary Griffith: Do you want to further drill down on this report?

Paul Oesterman, Chair: I don't know what ability we have to do that while still complying with HIPPA.

Mary Griffith: These don't include any benzos or anything else do they?

Carl Jeffery: No, these are only opioids.

Mary Griffith: Would it be a benefit to drill down to what else is being prescribed?

Beth Slamowitz: You could cross reference the top 10 prescribers with the top recipients to see if there are any connectors. Then you can look for maybe problem prescribers.

Paul Oesterman, Chair: We are going to look at the top 10 prescribers with a cross reference to the top recipients. We are looking for maybe some additional lock-in patients and prescribers that may need some education.

Chris Shea: The PMP will tell you all this information already and it defines how the patient pays. You may want to talk to the Board of Pharmacy because they track all this already. They are changing tracking to identify prescribers. Can you collaborate with the Board of Pharmacy?

James Marx: I'm not sure that is true, there are filters to track prescribers.

Chris Shea: They were not tracking prescribers is what I was told.

James Marx: It would identify prescribers that were over the normal. There was always a list of the top prescribers.

Chris Shea: But that information is there, it might make sense to collaborate with them?

Dave England: Can these databases be interrelated? Can the task force and the Medicaid data be combined?

Beth Slamowitz: The difference is Optum will pull the claims data for fee for service. The PMP should be able to pull the same thing, but it would include other payers if they can do that.

Dave England: But we still have to ask the question to compare.

James Marx: It would have to be done in tandem.

Beth Slamowitz: If they have the same fields available, they should be able to run the same report.

Paul Oesterman, Chair: Does the Board itself have access to PMP data?

Carl Jeffery: I think we would be ok to ask for an aggregate report. We wouldn't report certain doctors or patients.

Dave England: You would just do the same like this report with the identifiers.

Paul Oesterman, Chair: Our next step is to request the top ten providers to see if we can get PMP data cross referencing the existing report we have today. Is there anything else we want? We have a motion on the floor, and Chris has seconded.

Voting: Ayes across the board, the motion carries.

Paul Oesterman, Chair: Our next topic is utilization of agents used for the treatment of opioid induced constipation.

John DiMuro: Can I make a comment on that last section? I wanted to apprise the Board of some news. The controlled substance bill sponsored by the Governor will address everything we have discussed here. When it comes to the data, there are significant areas that lack, and I want to point those out to you. Number one is the providers you are going to research**.** We do not break down to pain specialist, addiction specialist, oncologist, primary care in the rural areas. So don't let the numbers fool you when looking at the top ten prescribers. Number two, you mentioned before, some patients filled 23 prescriptions in 12 months. That is ok if the provider has them on a two week plan. For some patients, it may be necessary for appropriate care to see that patient every two weeks. The high doses may be inherited from other providers. The other thing is what are we going to do with this data**?** If the DO Board had a problem with an

osteopath, they can send a document and the physician has to write back and the case can be closed. In the case of the MD Board, if they asked for a response in a letter, it was a formal investigation. Working with the Board of Pharmacy, we are going to make all the boards equal, so the boards can question the licensees. It will be up to the boards to hold the licensees responsible. Why would a patient receive so many doses from a prescriber? Because there are no flags in the PDMP. The PDMP is not working like it should. Dr. Rand was performing a service. I had a wait of three months to see me, so it falls on these primary care physicians to prescribe controlled substances. I can't blame the physician for that. We have to use our technology better. We need to put flags in the PDMP to catch prescribers. I don't want to prohibit a physician for being scared to write a prescription because we know the illicit will go up. The State of Vermont is going to see that with what they are writing in their bill. So what we are writing is getting buy in from all the groups including oncology. In one way, I want to let you know we have addressed everything you are talking about. In the other way, when you get that data, I ask you peel it apart. I asked the boards that when physicians renew their license, they indicate their area of specialty. I have recommended your level of training be your level of specialty. When we put the flags in the PDMP, now we can see if they are a family practice or someone else. If the flags are correct, we will be able to catch physicians.

James Marx: In the last two months**,** I have patients coming from oncologists that refuse to write for pain medications. It is a sad situation when a cancer patient can't get pain meds because their oncologist is afraid of making them an addict.

John DiMuro: I have not seen that. That is a shame.

Paul Oesterman, Chair: Over the years, I have seen a pendulum with prescribing of opioids. It sounds like the bill will address some of this. I appreciate you pointing out that we really need to look closely at the data. I would expect most of the prescribers to be pain specialists.

John DiMuro: You would expect that, but you may not be able to get that data. You are going to have to go to the boards or the individual to get that information. This is what I have run into while drafting this legislation. I didn't want the Board to go out of the way to get information that won't mean much.

James Marx: Which bill are you referring to?

John DiMuro: The governor's bill**.** We don't have a number yet. It is called controlled substances for pain. It is not just an opioid bill. It is all controlled substances for pain. Benzos are often used for pain, but we want to keep it open for other indications.

Paul Oesterman, Chair: We will ask for any public comment on the opioid induced constipation. Hearing none. For our opioid induced constipation, we requested this report.

Carl Jeffery: We put some PA criteria a few meetings ago, the criteria was enacted in October. Movantik's utilization dropped significantly. This report is a follow up. There is another new agent, so we will likely see this again.

Paul Oesterman, Chair: Does anyone on the Board have any further information on this? The evidence of the PA impact is on the graph. No additional action there. Item 7c, the

gastroenterology studies are not available. Can we defer that to the next meeting? The utilization of codeine containing cough suppressants, we have the utilization data. Looking at the data, the days supply per member seems reasonable. The usage appears to be seasonal which is to be expected. We have a number of different products that are in the breakdown that are a combination of guaifenesin and codeine. I don't know how they are listed as brand or generic.

Carl Jeffery: They have a different name, so they fall in the report as a separate product.

Paul Oesterman, Chair: The big one is still the promethazine with codeine.

Carl Jeffery: The column second from the right is the most telling. There is nothing out of line here, between 100 and 200 mls per prescription.

8. Public Comment on any Standard DUR Report

9. Standard DUR Reports

Paul Oesterman, Chair: I don't see anything we need to review further on this, anyone else on the Board?

The next item is any public comment on any standard DUR report? Seeing none. We have our prescribing/program trends. Looking at Q3 and Q4 is identical, it looks like someone did a copy and paste. One of them is not right. On the top 10 drug by claim, quarter 4 of the classes are in the same order as quarter 2, but the pharmacy paid amounts are different. Q3, the ulcer drugs jumped into the fray. It is interesting to see a good trend, the opioid analgesics show a gradual decline.

Carl Jeffery: The hepatitis agents, on page 91, appear to be stabilizing. I still don't know how to manage hemophilia agents. Those are going to take some specific case management.

Paul Oesterman, Chair: Anyone on the Board have any comments on these reports? Seems like the quantities are all reasonable for these medications.

Carl Jeffery: Speaking of maintenance, we are going to start February 20, a mandatory maintenance medications. After the first fill**,** will require a three months supply minimum.

Mary Griffith: We do not include long term care claims.

James Marx: What is the intended, compliance or cost?

Carl Jeffery: A little of both, our dispensing fee is $10. If we can eliminate two dispensing fees**…**

Paul Oesterman, Chair: Would we see a report at the next meeting to see how that is progressing?

Chris Shea: Are you going to require that? Part D has short cycle drugs and 30 day supplies. If you require 90 days of a branded drug of an expensive drug, for the cheap drugs makes sense, but for high dollar drugs…

Carl Jeffery: We set a threshold of $500 per month, because some of the antidiabetics are expensive, but none of the agents hit $500 per month with the normal dose.

Beth Slamowitz: I think after some time, we can change the threshold, but we needed a starting point. A lot is access to care, especially in the rural areas. Many pharmacies may not know about the ability to get a 90 day supply.

Chris Shea: I think it makes sense for a lot of medications. Every time you touch a prescription**,** it costs money. I just thought for the high dollar drugs, it may not make sense.

Beth Slamowitz: We looked at that list, and that threshold may change.

Carl Jeffery: It doesn't take too many lost prescriptions before we lose any benefit.

Mary Griffith: If they have a primary insurance, then we should not require this.

Carl Jeffery: Right, we follow the rules of the primary when they have one.

Paul Oesterman, Chair: We have our pro-DUR and Retro-DUR. Carl, do you want to give us an update**?**

Carl Jeffery: For the retro-DUR, we will have something next meeting, we are in a transition. The Pro-DUR is just more of the same. I don't see anything that stands out on this one.

Paul Oesterman, Chair: These include physician administered claims because there is a lot of midazolam**.**

Carl Jeffery: Right, we process the physician administered drug claims and we use this edit to catch duplicates.

Darrell Faircloth: Do all physician administered drugs come into the pharmacy system?

Carl Jeffery: Yes.

Mary Griffith: These DUR edits, on NVPAD claims, who gets the message**?**

Carl Jeffery: If a pharmacy runs it, they will see the message. The only ones we really apply to the PAD claims are the duplicates, and that is how we edit that. It is a hard stop, messages don't go anywhere. A pharmacy would see it if the PAD claim came in before they ran it.

9. Closing Discussion

Paul Oesterman, Chair: Any comments on these reports? Is there any other public comments?

Our next meeting is April 27, 2017. We should have a discussion of the time of the meeting, is this time ok?

Chris Shea: This time works for me.

Paul Oesterman, Chair: Ok, we will keep it at 5:15. The meeting is adjourned.

Meeting adjourned: 7:08 PM