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**Nevada Medicaid
Drug Use Review (DUR) Board
Meeting Minutes**

The Division of Health Care Financing and Policy (DHCFP) Drug Use Review (DUR) Board conducted a public meeting on July 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; Dave England, Pharm.D.; James Marx, M.D; Larry Nussbaum, MD

Board Member Absent:

Jeff Zollinger, DO; 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

Others:

Lori Howarth, Bayer; Scott Larson, BMC; Lisa Borland, Vertex; Cathy Gross, Vertex; Joe Hubbard, CNUCOR; Sandy Sierawski, Pfizer

1. Call to Order and Roll Call

Meeting called to order at 5:32PM.

Roll Call:

Carl Jeffery - Catamaran
Jim Marx - Las Vegas Pain Management Physician
Larry Nussbaum - Reno School of Medicine
David England - Las Vegas Pharmacist
Paul Oesterman - Pharmacist Reno Chair
Darrell Faircloth – Senior Deputy Attorney General
Beth Slamowitz – HP
Mary Griffith – Nevada Medicaid
Coleen Lawrence – Nevada Medicaid

2. Public Comment

Sandy Sierawsky – Pharmacist in Nevada – Pfizer/Medical Division:

Requested board review prior authorization criteria for the oral anticoagulants Pradaxa, Xarelto, and Eliquis. Eliquis has been approved by the FDA for an additional indication, so we would like the criteria used so that it could potentially be incorporated in that criteria.

PO: Because it's not an agenda item, we will add it for the agenda for next time, that way it will be actionable.

3. Administrative

Review and approve April 24, 2014 meeting minutes.

JM: Motion to approve minutes.

DE: Seconded.

Discussion: None.

Board votes unanimous, "Aye."

Minutes approved.

4. Status Update by DHCFP

Mary Griffith – RN, Pharmacy Services Specialist:

Provided the following updates: OPR, (Ordering Prescribing Referring) physicians, we've been talking about that for several months now and we actually have the implementation date. There are web announcements in the back. It's going to be effective/ soft edit/ a portion of it goes into effect August 18th, 2014. That means that if there is a drug that is prescribed by someone who is not a Medicaid provider, there will be a message that comes up that says "This prescription is prescribed by someone who is not enrolled in Medicaid". Next time that fill comes in, if it's after October 1st, it's going to deny. October 15th is the hard edit. So for

October 1st too, it's going to be effective for everybody, not just pharmacy, so if you have any physicians that you go and visit, they will be effected by this also.

Board: When is that effective?

Mary: October 15th. That is when the hard edit hits. The soft edit starts next month.

Coleen: It's common obviously, already, in the pharmacy world, this is on the record, and Medicare has already implemented it. It's implemented in other states and has been implemented in other states for years. I think pharmacy is going to be a natural transition. It's expected in the pharmacy world. I expect that we're going to see unknown impact. It's going to be in other areas in healthcare where there's what I call the triad. And the triad would be physician, or a prescriber; a supplier; and then another provider, so a direct service provider. A good example would be a home health provider, or a DME company. That's where it's going to get a little trickier because the ordering and the direct servicing is going to be a little bit different. As a physician, it's going to be an education pattern that we're going to have to get out there with.

Mary: The hope is that when the pharmacist sees that new message that they inform the recipient. "Hey your doctor is not a Medicaid provider. Next time, if you need a refill on this, it's going to get denied." so that the recipient can go to their own doctor and get them on our enrollment.

PO: Is there a bypass mechanism for somebody who is taking call or covering for a Medicaid provider who is himself not a provider?

Coleen: The only way that I would say in that kind of a scenario, is interns, such as in the emergency room, hospitalists and interns are not applicable to this rule. They fall under the hospital benefit themselves, so that's the only caveat, if you want to say taking call for somebody, that's the only exception to this rule.

LN: So trainees, like residents?

Coleen: Residents are not applicable, interns...

LN: Even if they're in a clinic, not in a hospital?

Coleen: If they fall under the resident role, and I mean the Medicare Resident role, those are the only ones. You're required to have your NPI and follow those rules, you must fall under the OPR.

Mary: Also, there is going to be a mechanism for 30 days after the hard edit for the pharmacist to be able to override, if they come across someone that doesn't have that provider enrollment. They will be able to override that, but that's only going to happen for the first 30 days and then it's going to be turned off.

Coleen: That's only for Pharmacy.

DE: And that's until 11/15, they can override if they need to?

Mary: Right.

The Governor has created a controlled substance task force. Very high level, different political people that are involved in it. Our administrator Laurie Squartsoff is involved in it also. I'm not sure how often they meet, but it's definitely something that we're following because it's gone to the Governor's level on this. We're still involved with the substance abuse task force for the Board of Pharmacy. They haven't had a meeting recently, I don't think, but we're definitely involved with that in encouraging physicians to enroll in the PMP program.

JM: There actually is movement afoot through the Pharmacy Board to be registered at the time of medical licensing (and possibly DOs), or will be required to do that as a part of their relicensure. There will be virtually 100% enrollment. That doesn't mean 100% participation.

Mary: Next month we have someone from the Board of Pharmacy that is familiar with the PMP program to come talk to us [about the changes being made] in October.

Coleen: We're continuously recruiting for positions, whether it's on this board, or the P&T, because we have an open position that will be on the P&T for a psychiatrist. Our goal is to expand the participation on this board by statute of ten members. If there are any nominations, please send them to our office and we'll work with our director for this board, and we'll work with the Governor's office for the P&T. For this board, we're looking for Best Practice and Standards of Care for clinical criteria and utilization and the P&T is strictly for the Preferred Drug List.

PO: Any updates in terms of Healthcare Reform?

Coleen: Last month they hosted the National Association of Medicaid Directors conference in Tahoe. We had feedback from all the different states about what was going on with Healthcare Reform. I will state that Nevada ranked as one of the only states that did a full Medicaid expansion duplicating the current Medicaid benefit. So we're still really proud of that decision by our Director and our Governor to fully replicate our current Medicaid benefit plan as a single Medicaid program. What we have learned from all the other states, if they chose to expand Medicaid, that was step one. Step two was really narrowing their benefit plan. Although there have been hurdles of what's happened on the Medicaid side, I will definitely say that it's been very seamless as to what has happened with our Medicaid expansion. Our eligibility population has grown tremendously. They're projecting somewhere in the area of 500,000 by the end of the year for Medicaid expansion. I can get you the exact numbers, but they are posted on our DHS website, but those are the numbers I keep hearing. On a positive note, at our lowest point of Medicaid expansion, we had up to 60,000+ applications in the queue for our backlog of eligibility. I was at a meeting on Tuesday, and the Division of Welfare and Supportive Services said that they have approximately 6,000 applications in the queue which is by far the best they have ever had in their history. So this administration and DWSS's administration have definitely put all of their resources forward in doing improvements on their welfare process to really streamline what's going on in there. Whoever touches the application is the one who finishes the application. It's very positive on the eligibility side. We're hearing that there are literally determinations that day on eligibility now, so it's very positive.

Very big push for us, on the Medicaid side, to work with our providers to encourage providers to actually accept Medicaid patients. What we're trying to do is figure out what are the barriers. We wake up every day saying "We're not that system who wants to deny patients, or deny care. And we don't want to deny payment." So what we're doing is going out there and in meetings like this, I was in a meeting for the last two days where the federal government is trying to figure out why people are not taking Medicaid. So what we ask for is any feedback as to what are barriers of why people are not taking Medicaid. Our administrator has really put the focus on us to figure out, whether it's prior authorizations, myths...that's our biggest focus right now.

JM: Is there any type of formula for how patients are distributed to managed care verses indemnity? How is that working out?

Coleen: For managed care verses fee for service?

JM: Right.

Coleen: I'll have to get you what the actual numbers are. I do believe that the majority of them are going into the Managed care system because of the dynamics of the state. They're going into urban Washoe, or urban Las Vegas, and well the last numbers I saw, that's what

they were. I would have to get you those specific numbers, but that's what the projections were because Fee for Service would be the (rural). They are falling into the newly eligible calculation which is going into managed care. They are not coming into Fee for Service.

JM: In Managed care, there are panels. Is the problem recruiting into those panels?

Coleen: What we are finding is that it doesn't matter whether you are cash patient, if you are Managed care, fee for service, Medicare. We have a stress on our entire healthcare system right now. Honestly, our own employee system is having a hard time finding doctors right now. Everyone has a long wait list right now. It's not just Medicaid, but my issue is to be concerned with anything we can do to reduce any type of barriers that are out there. So one of our largest focuses right now is to make sure that managed care and fee for service are as streamlined as possible, so Beth and Carl took on a very large project and they are trying to make sure that, for example, our PDLs looked similar, so when a physician looks at it, it looks somewhat seamless. So we're looking at even those types of minute little things to make sure that we are streamlined. But yes. They are going primarily into managed care.

5. Presentations:

a. Annual DUR Report Presentation – Carl Jeffery - Catamaran

(Carl hands out packet to board members) This is a late addition that we've added here, so I apologize for not getting it to you guys sooner for you to review it. This is due September 30, 2014 to CMS Since this is the last meeting before that date, we scrambled to get this put together. Standard answers, very similar to what it was last year. I think the numbers that we'll call out that are different that I think are improving are like the generic trend. So if you look, starting on page 7, see the number of generic claims. It's on the very bottom and then it splits and carries over to page 8. Our generic dispense rate is 80.5%. And this is 2013. We're pushing 82% now and this continues to climb as more generics are available. But still it only makes up 22% of our total expenditure, so that's a huge difference. As more specialty products and biologics hit on the market, the brand names are really pushing the prices up.

PO: Carl, for that 80% is that for those products that have a generic available, or all dispensed?

Carl: That's all dispensed generics. Our rate of dispense when there's a generic available is over 99 percent. There's not too many and think most of those are on the preferred list. We have a little bit more work to do for cost savings and cost avoidance. These are numbers we've shared before with the DUR board. We're just going to roll those into an annual report instead of the quarterly.

CJ: On the early refill, what is the rationalization for utilizing 80% for one class of drug and 90% for another?

Coleen: The DUR board actually made that recommendation back in 2007 or 2008. There was one tolerance level. At the very beginning when the controlled substance focus started. We started that. That's when the recommendation happened because that's what a lot of states do. They tighten it up on that side.

Carl: CMS is doing a better job about getting these every year they update these reports and ask for different information, for example this year they are asking for e-prescribing trends. They've asked for these cost savings numbers for retro-DUR before and they are doing a better job of rolling these in and getting them back out to the public. We should be seeing standardization across the board.

PO: We need to approve this report for submission, so I'll ask for a motion to approve it.

LN: Motion to Approve.

PO: We have a motion, do we have a second?

DE: Second.

PO: We have a motion and a second to approve the Preliminary Annual DUR Report for CMS. Any additional discussion?

Voted: Unanimously to Approve.

b. Discussion of proposed adoption of updated clinical prior authorization criteria for the medications used for acne – Carl Jeffery – Catamaran

Public Comment: None

Carl: The first page in there is chapter 1200 as it is now only one criteria is that they have to be under 21. So our proposed criteria is to add some criteria to those 22 and over, because we do receive periodic requests and I think there are adults with acne that can lead to infection and scarring, so we want to make sure we have the option available to treat these, so our proposal is that we add the criteria here that would 22 or over with a diagnosis of moderate to severe acne grade 2 or higher. I included a graph if you want to look at the utilization. Almost all of these are going to be patients that are 21 and under. But still the high ones are the Clindamycin, but they are appropriate levels after working through the topicals and then our oral tretinoin are very few. They are following the appropriate guidelines.

PO: There was some consideration for possibly utilizing the oral tretinoin products for just grade 3 or grade 4. Do you know if any of the other programs do anything like that?

Carl: It's across the board. Some other Medicaid programs don't cover these at all because they see them as strictly cosmetic, other ones are pretty open to adults. The criteria that is proposed here is by the clinical call center who does handle other Medicaid programs. This is pretty standard to what they are accustomed to seeing. They've got such a strict REM's set up for the oral tretinoin anymore, we're just adding more hoops to jump through to get those medications.

CL: You already have an overarching criteria that drugs can't be used for cosmetic reasons the call center will be looking at this in addition to that, correct?

PO: In essence we are looking at allowing those patients who fit the criteria of twenty two and over and with grade 2 or higher to include them in being eligible.

JM: Is there any P&T guidance? The thing that really jumps out, other than that tretinoin compound is the benzoyl peroxide – Clindamycin combinations being 100 times more expensive than the individual components. Is there any sort of step type therapy?

Carl: We do have a couple of classes, topical retinoid and combination agents. We've got Retin-A micro, Tazorac, and Ziana as preferred.

JM: Not as much concerned about the Retin-A as the clindamycin.

Carl: We've got the topical benzoyl peroxide antibiotic and combination products out there too.

JM: Those are like dirt cheap and until they combine them and then all of the sudden...

Carl: We've got the BenzaClin as one of our preferred agents.

CL: If you wanted to make a clinical step, you guys could do that, because they are just doing it for an entire class.

JM: The Clindamycin phosphate, for 921 Claims is \$41,000, but for the BenzaClin, for 250, it's twice that.

Carl: What you're not seeing is the rebates coming back in. By having a preferred list, that's the whole point of it.

CL: The history of it is this. In many states, the reason the criteria is set under 21 is because it is looked at as cosmetic. Then states had to allow it for children because of the EPSDT rule. Then it was kind of pushed on throughout the years to where adults can have it. Now we've been pushed on and said "What do you do?" Some states allow it and some states stick with saying it's cosmetic for adults. If you treat the acne early...you get pushed on enough and say "What do you want to do?" There are still those cases on the edge. So I think we have a protection in the regulations so it can't be cosmetic, I won't get in trouble on the regulatory side. If we can put something in there that says medically that over 21...

PO: Is there going to be any kind of issue with the grading, the four grades of acne?

Carl: Moderate to Severe means grade two or higher. We can be more aggressive to start. It's always easier to be more aggressive then back off, then we can try to ramp up if we find out that utilization is going crazy. I think by the time they get moderate to severe grade acne, it's to the point of fulminating cystic acne where it's going to cause health issues.

DE: That's where grade two starts anyway.

Carl: I believe so.

PO: Cystic – I think that's three. Would it be possible for grades 1 and 2 to have certain medications available, then three and four, other medications are available? Set it up that way as opposed to anything's available?

Carl: There are clinical guidelines from the American Academy of Pediatrics that defines mild to moderate to severe and also there are some dermatology guidelines. The American Academy of Dermatology also has some recommendations.

DE: Could we possibly make an amendment to section B to make that grade 3 or higher as opposed to grade 2?

Carl: Certainly.

DE: I would think that by the time the patient reached 22, they would have already been on some sort of therapy and persisting after that age, it would be more severe therefore it would justify going to that. Whether they have come to and began a Medicaid program or had been in a Medicaid program, there would have been some treatment prior to that.

What we've got is a revision to the proposed prior authorization criteria with the new addition being the recipient is 22 years of age or older, and has a diagnosis of grade 3 or higher. Prior authorization would be good for one year. Can I get a motion for these proposed criteria?

PO: Can I get a motion for these revised proposed criteria, with the addition being the recipient is 22 or older and a diagnosis of grade 3 or higher of acne. The prior authorization would be good for one year?

DE: So moved.

JM: Second.

PO: We have a motion and a second. Any further discussion? None. All those in favor of the revised proposed prior authorization criteria

Voted: Unanimously to Approve. Motion carries.

c. Clinical review – Xolair – Carl Jeffery – Catamaran

Public Comment: None

Carl Jeffery – Catamaran - Proposed addition for treatment of the urticaria as a new indication for this product. No changes to the actual treatment of asthma, just the addition of the urticaria. I did look into other treatments with H2 blockers for treatment of urticaria. It's really not indicated for that, but they've done some studies and a lot of studies are really old and not well controlled. They weren't blinded or anything. A lot of them were done with hydroxyzine. They think it had more to do with the cimetidine boosting the effects of the hydroxyzine, than the cimetidine having an effect itself. It's really not that much of an impact. But still the criteria is to have the H1s first, oral antihistamines first then go on to the two.

DE: This would still be a relatively limited access anyway. Even using Xolair, even for the asthma.

Carl: We average in the low 20's the number of people who are on this.

PO: Do you recall what the rationalization was for the prior authorization being 3 months? Would it make it easier on the call center if it was one year?

Carl: Yes. It would mean fewer calls.

DE: What I don't recall of the top of my head is where it says chronic idiopathic urticaria I don't remember the underlying passage of what is causing it. It doesn't make sense. By the virtue of saying chronic idiopathic, it would make sense to say the one year approval time as opposed to three months if it's going to be an ongoing process. But I can't recall what would stimulate this, if there was any seasonal variability with it.

Carl: I'm not familiar enough with it either.

DE: I like the criteria though.

CL: The first part of it wasn't for someone who was chronic.

DE: The first part was for persistent asthma that can flare up, but at the same time with chronic idiopathic urticaria...I've dispensed it for patients with asthma, but never for a patient with chronic idiopathic urticaria (CIU), so I'm not that familiar with that utilization of it. If I remember correctly, even when we were using the Xolair, the patient had to meet all of the criteria too. Plus it is limited as to who can prescribe it. Up here we see that it has to be prescribed by the pulmonologist, allergist, and immunologist. We're leaving it pretty open down here in the CIU. Would we want to add the allergist, immunologist section and/or rheumatologist down there as opposed to leaving it for anyone to order because the criteria for Xolair is quite extensive? It has a black box warning. Would we want to add dermatologist, allergist, and immunologist down in the criteria part B in the 'iii' section, moved down one level? Put who can prescribe it in there like we've included up above. In addition we have that the recipient's current weight must be recorded. I think that should be added to the CIU indication also because it's weight based.

Carl: Dosage is also dependent on pretreatment IGE results.

PO: So we've revised the proposed prior authorization criteria, we're not touching the indication for severe persistent asthma, What we're looking at doing is adding the diagnosis of chronic idiopathic urticaria with the proposed criteria of the present here and adding that the prescriber must be either a pulmonologist, dermatologist, or a rheumatologist and recipient's current weight must be recorded. Also extend the prior authorization period to one year. For both.

Carl: For the chronic urticaria, it's not weight based dosing. It's just 150 or 300 mg dosing once every 4 weeks.

PO: How do they determine whether it's for 150 or 300? [Drug information] says dosage of Xolair in CIU patients is not dependent on serum IGE level, or body weight. It just says 150 or 300, but doesn't give any criteria. Not going to add the weight.

Carl: Just to be clear, the motion is to add the specialist, dermatologist, pulmonologist, rheumatologist, the CIU indication, and to increase the prior authorization to 12 months.

DE: I'll move we accept this

JM: Second

PO: Motion and second. No further discussion, Advised Proposed prior authorization criteria for the use of Xolair for both the severe persistent asthma and chronic idiopathic urticaria, with 12 month approvals with prior authorization.

Board: Voted unanimously – Aye

PO: Motion carries.

d. Clinical review – Ivacaftor

Public Comment: Lisa Borland – Medical Affairs with Vertex Pharmaceuticals – Addressing the committee in reference to Ivacaftor. It's known commercially as Kalydeco. First and only available therapy that targets the underlying causes of cystic fibrosis. The underlying cause is a defect in what is called the CF Terra protein. CF terra protein primarily functions as a chloride ion channel. This is really important in regulating fluid and electrolytes across various epithelial tissues – the lung, the pancreas, and the digestive system. Estimated 30,000 persons with cystic fibrosis in the United States. According to the 2012 Cystic Fibrosis Foundation patient registry, there are an estimated 186 patients in the state of Nevada. Kalydeco is indicated for a very specific subset of the CF population. It was originally approved in January of 2012 for persons 6 years of age and older with a mutation known as G551D. That mutation is present in less than 4% of the overall CF population. In February of this year, the label was expanded to include 8 additional mutations. These 8 additional mutations account for less than 1% of the overall CF population. That indication was added for 6 and older for those 8 additional mutations. Should also add that it is not effective for those who have 2 copies of the 508 Dal mutation. That's the most common CF causing mutation. The efficacy of Kalydeco in persons with the G551D mutation was supported by two phase 3 clinical trials – one in persons 12 years of age and older, the other in patients 6-11. In both those studies there was a statistically significant improvement in lung function as measured by percent predicted FEV-1. That was assessed at 24 weeks. The treatment effect was 10.6 in the adolescent population and 12.5% in the pediatric population. Those levels of lung improvement were sustained through 48 weeks of therapy. Those were seen regardless of age, sex, level of disease severity, or geographic location. Patients treated with Kalydeco also saw improvements in weight. In both the adolescent and adult population there was a decrease in risk of pulmonary exacerbations, as well as improvement in patient's respiratory symptoms. The study evaluating and supporting the efficacy for the 8 additional mutations, for which Kalydeco recently gained approval. In the smaller study, because those mutations are very rare, 39 patients, it was an 8 week cross over study. Those patients responded very similarly as the G551D population. So an improvement in percent predicted FEV-1, 10.7%, we didn't see the reduction in risk of pulmonary exacerbations, because the study was only 8 weeks and was too short, but an improvement in MMI and patient reported respiratory symptoms. The safety profile is really based on the three original registration

studies. The discontinuation rate due to adverse events; in the Kalydeco treated patient, it was 2%, that's compared to 5% in the placebo treated patients. The serious adverse events that occurred more commonly with Kalydeco than with placebo, whether or not they were determined to be drug related by the investigator, were increased liver enzymes, abdominal pain, and hypoglycemia. The small study - safety profile was very similar to what was seen in the G551 population.

DE: This basically improves quality of life, but about longevity?

Lisa Borland: The therapy has been on the market for two years, so there isn't enough information to prove its effect on survival. We do have modeling data that suggests that, based on the improvement in just FEV-1.

DE: With the patient being required to be 6 years of age or older, were tests not done on anyone younger than that? Or are there possible studies to be done on younger patients?

Lisa Borland: The dose is the same in those 6-11 as in those 12 and older. The pill is about the size of a large multi vitamin. The pediatric patients just can't take those. The pediatric patients have not been evaluated yet and it would require a different formulation. As of now, though it's outside of the labeled indication, a pediatric study has been conducted in 2-5 year olds with a different formulation.

DE: It's probably a "Do not crush" then.

Lisa Borland: I don't know that the formulation has been released publically, but it is not a large multi vitamin. It's a pediatric formulation.

DE: In the studies do you also see a decrease in hospitalizations?

Lisa Borland: In the phase 3 studies, particularly in the adolescent and the adult population, we didn't see very many pulmonary exacerbations in the pediatric patients, in general. Lung function doesn't start to decline until adolescence. Pediatric patients have healthier lungs. What we saw with hospitalization was a tertiary endpoint in the adolescent and adult population. I didn't see a significantly decreased rate of hospitalizations themselves, but in the duration of the hospitalizations and duration of IV antibiotics, and the duration of those pulmonary exacerbations, when they occurred, and how they were treated, but not the numbers or the even rate.

DE: With this onboard, were there any issues with the patients, if there were a hospitalization, or even outpatient, were they still able to use the inhaled antibiotics, or did it always require, if they had exacerbation, hospitalization where they had to have IV antibiotics as opposed to inhaled or oral.

Lisa Borland: There's no standard definition of pulmonary exacerbation. The way that they were evaluated or defined in clinical trials was 4 of 12 sinopulmonary symptoms and either a change in antibiotics, or an addition of an antibiotic. It wasn't necessarily related to IV antibiotics.

PO: So what we have in front of us is the proposed criteria, amended from what we did have to include the new mutations, as well as the inclusion of the 6 years of age or older criteria. Motion to accept and seconded. No further discussion

DE: Motion to accept

LN: Second

Board: Voted Unanimously - Aye

PO: Motion carries.

e. Clinical review – Updated prior authorization criteria for those medications used to treat ADD/ADHD

PO: We have the previous criteria that was last reviewed in January of 2008. No proposed changes. Just time to take a look at the criteria for review. Call for anyone in the public domain that wishes to speak.

Sandy Sierawsky – Pharmacist in Nevada – Pfizer/Medical Division:

This was addressed in the April meeting, but one of the things that the state wanted to see changed was the removal of the DSM terminology. That's what was discussed. The other issue I wanted to resurface is that it's pretty restrictive criteria for those who are not psychiatrists. If you look at the data that IMS provides, prescriptions for long acting stimulants make up about 60% of treatment for ADHD. Out of that 28% is prescribed by psychiatrists. 72% is prescribed by pediatricians, primary care physicians, etc. Nationally, psychiatrists aren't prescribing the bulk of these medications. The American Academy of Pediatrics require pediatricians to diagnose and treat ADHD. They provide guidelines for them to follow to identify causes, symptoms, vulnerabilities, etc. Nationally, pediatricians provide about 66% of all office visits for children in Medicaid. I feel that the criteria is too restrictive to allow for those healthcare providers to provide treatment.

LN: Is this still being done like this? Where, when I'm writing a prescription, I'm still having to get a prior authorization even when putting down a diagnosis?

Coleen: Top prescribers in Nevada are psychiatrists, not pediatricians.

Sandy Sierawsky: Right because it's too difficult for the pediatricians to write the prescription because the criteria doesn't allow it. They probably just pass on the patients to a psychiatrist.

Coleen: We've also talked about the overall behavioral health of the children. We still have a very high utilization of these medications in Nevada, if you look at the data.

DE: The point of the criteria is to have a psychiatrist in the mix, so that the patient can be evaluated for need. This prevents a child being put on the medication just because there was a complaint from a teacher.

Board discussion: Reviewed Prior Authorization form. How Nevada differs from other states in this matter is the requirement of follow up care. Patients must be seen during a certain timetable. How do we assure that people get appropriate treatment?

Board discussion: Use of the DSM 4 – Updating policies. If the ICD-9 language can be taken out of the policy, (where it's not applicable to the actual policy) it will be removed. If it is pertinent with ICD-9 and it needs to be updated with ICD-10, we cannot make that change because ICD-9 and ICD-10 cannot be run at the same time and it can't be changed to ICD-10 until next October.

Board: Board acknowledges the fact that they have reviewed the updated prior authorization criteria for those medications used to treat ADD/ADHD, but no changes will be made.

Board: No action being taken.

f. Clinical review – Prior authorization criteria for transdermal fentanyl system

Call for public representation: None

Board discussion: Last review by the DUR Board was July 30th, 2009. No proposed changes.

Discussion of criteria of using multiple long acting pain medications and limits set up by the criteria. Suggestion of eliminating item 1C from criteria. Need a better way to handle multiple drug prescriptions for pain, so that abuse can be stopped and doctors can actually prescribe what the patients need.

Carl to bring this discussion back to the next meeting for review. Mentioning morphine equivalent dosing that is ok to move to transdermal fentanyl. Criteria stating the prescriber has checked the PMP.

No action being taken to modify the criteria at this time.

g.DUR Board Requested Reports

- 1. Top 10 Black Box Warning Medications** – Being deferred until next meeting. Open to audience discussion.
- 2. Controlled Substance Utilization on Trials Report** – Carl Jeffery – Same report as was presented during last meeting. Hydrocodone and Acetaminophen are the highest prescribed medications. 500 mg Acetaminophen is no longer available after January, so it's not on the report. Pretty significant spike in drug utilization, but there has been an increase in Medicaid membership as a whole. Promethazine with Codeine has really dropped off.
 - Carl to bring criteria next meeting to discuss Lock-in program. Consider amending criteria.
- 3. Psychotropic medication use in Children** – Report filters diagnosis by age. Appears that the adolescent population is spiking. Count of diagnosis by specialty. The program that pulls the reports doesn't duplicate the numbers. The primary diagnosis is captured. If the child is on an additional medication for another diagnosis, that diagnosis is not captured on the report. The population of children on psychotropic medications is very high.
- 4. Pro-DUR edit on late refill correlation to ER visits** – still pending.
- 5. Buprenorphine and Buprenorphine-naloxone use** – 2 reports and the Board is asked to return the color coded copies when finished in insure no potential HIPAA violations. Looking at continuity of care with these products. Reports show that the patients are very compliant in taking the medications, or at least getting them filled. Possible criteria for initial fill to limit the quantity for the first 30 days with the requirement of ongoing 30 day fills after the initial fill. Main concern is paying a dispensing fee each time. There are other states that limit the dispensing fee to once a month. Will evaluate how it is done in other states.

h.DUR Board Standard Report

Carl presented drugs by diagnosis. Top 10 prescribed. Everything looks consistent. Hepatitis agents have moved up while Hemophilia has dropped off since the first quarter. Abilify is one of the top medications. Significant change in amount+ spent can be attributed to a few new members that require a very large dose of medication at a time. Abilify to go generic in 2015. Oxycontin should be going generic soon. Generics have been approved. Purdue has a competing product with Zohydro coming out.

Request: Albuterol or asthma medicines as a whole – breakdown of how patients are using the drug and how effective it is for treatment.

Request: Tussionex report

Retro DUR Report: Looking at A-typical antipsychotics in pediatric patients. If they are on 2 or more a-typicals outside of their approved age. Study is not finished. Hoping for feedback by next meeting.

Possibility of going paperless discussed.

6. Date and Location of next meeting

October 23, 2014, at the Best Western in Reno.

7. Adjournment

Meeting Adjourned at 7:53PM