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**NEVADA MEDICAID
DRUG USE REVIEW BOARD
DRAFT MEETING MINUTES**

Date of Meeting: Thursday, January 28, 2016 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; Michael Owens, MD; Paul Oesterman, Pharm.D.
Chris Shea, Pharm.D.; David England, Pharm.D.

Committee Members Absent: Jeffrey Zollinger, DO

Others Present:
DHCFP: Coleen Lawrence, Chief, Program Services; Mary Griffith, RN, Pharmacy Services Specialist; Darrell Faircloth, Deputy Attorney General
HPES: Beth Slamowitz, Pharm.D.
OptumRx: Carl Jeffery, Pharm.D.; Susan McCreight

Others: Laurie Squartsoff, DHHS; Chris DeSimone, Aegerion; Deborah Profant, Alkermes; Jeff Stockard, Wallbert; Tim Butler, Walgreens; Shane Hall, Purdue; James Kotusky, Gilead; Jennifer Lauper, BMS; Gregg Gittus, Alkermes; Sylvia Churchill, Amgen; Jen Yew, Astra Zeneca; Bret Ferguson, Pfizer; Sergio Gonzalez, Takeda

Others On Line: Lori Howarth, Bayer; Laura Hill, Abbvie; Christopher Conner, BMS; Rob Bigham, Shire; Andrea Scherschel, BMS

March 4, 2016

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1. Call to Order and Roll Call

Meeting called to order at 5:25 PM

Roll Call

Michael Owens
James Marx
Dave England
Chris Shea
Paul Oesterman, Chairman
Darrell Faircloth
Coleen Lawrence
Beth Slamowitz
Mary Griffith
Carl Jeffery

2. Public Comment on Any Matter on the Agenda

Paul Oesterman, Chairman: Public comment? Please limit comment to no more than 5 minutes. No public comment.

3. Administrative

- a. **For Possible Action:** Review and Approve Meeting Minutes from November 5, 2015.

Minutes reviewed.

Dave England: Move to accept minutes as presented.

James Marx: Second.

Votes: Ayes across the board, the motion carries.

- b. Status Update by DHCFP

Paul Oesterman, Chairman: DHCFP Status updates.

Coleen Lawrence: Coleen Lawrence with the Department of Health and Human Services.

We put together a pharmacy tool kit. It is geared toward the manufacturers. It is not geared toward the general public because we use a lot of acronyms. We tried to make this an education tool for physicians and manufacturers. We get a lot of questions, and this hopefully answers most of the questions. This lives on the Division website, called the "Pharmacy Toolkit". It gives a high level overview of the Fee for Service. It talks about the P&T and the DUR Board, the roles and responsibilities of each are highlighted. We have some hints and statutory requirements. A new contact is listed on the form; it has a dedicated email box just for pharmacy questions.

Federal Upper Limit pricing update, NADAC was started 11/1/15. The FUL pricing is a known issue and the FUL is lower than the NADAC price and we are allowing overrides on those.

The CMS final rule did get released. It has been since 2010. We are reviewing it right now for final comment.

I am no longer with Nevada Medicaid. I will be with the Director's office, still within the Division. I will still be involved in pharmacy but at a higher level.

4. Board Action

- a. **For Possible Action**: Discussion on Hospice Program proposed changes to criteria.

Paul Oesterman, Chairman: The next agenda item, proposed adoption of prior authorization criteria for all prescription drugs for the Hospice Program recipients over the age of 20. Do we have any public comment? We will hear a presentation from Beth.

Beth Slamowitz: HPE put together a presentation for the Hospice Program and presented to DHCFP. We took some of the pharmacy issues out of that presentation and have it here. We looked at FY2012 to last year FY2015. The overall increase has held steady for this year. Some of the increase being due to messaging and the demographics. This gives an overview of the recipient count within fee for service. We looked at the age groups, under 21, 21 to 64 and then over 64. The over 64 has been decreasing, our pediatric population is the fastest growing. The primary diagnosis for those on hospice, cancer is on the top. Similar to national numbers. We focused on the pediatrics because of the increase. Some changes include the Patient Protection and Affordable Care Act was signed into law, which enacted the concurrent care for children requirement. It was intended to make hospice available without foregoing any other services that may be available. The ACA does not change the requirements, the physician does need to verify the life expectancy is less than 6 months. Some of the concerns we had, the hospice medical directors, are also the ones certifying the terminal illness. This can be seen as a conflict of interest. Without a PA requirement, the potential conflict of interest is never addressed. Looking at payments by age group, the under 21 has a significant increase. The other groups have been steady, looking just at pharmacy and the drugs given to hospice recipients. There were 6700 claims and total expenditures just over 1.1 million. A spike in spending from 2014 to 2015. The specific drugs Medicaid is paying for, Synagis is the top of the list for the entire hospice recipient group. We have Harvoni, which brings into question why Medicaid would pay for that.

Coleen Lawrence: A good reminder of the procedure is to put it in perspective. Our current process is if a drug is related to the hospice condition, then it is covered by the hospice facility. If it is not related to the hospice condition, it will be paid outside the facility cost. The pharmacist is allowed to key the override stating it is not related to the hospice condition.

Beth Slamowitz: Currently in the POS system, the initial claim will reject for hospice. The pharmacy can enter a code to override the hospice limitation. So the pharmacy is

certifying if it should be billed to hospice or Medicaid. We also looked at the top 10 drugs by claim counts. These are obvious drugs that should be paid through the hospice benefit. Pain treatment, or nausea and vomiting treatments should be hospice.

James Marx: What about the compound drugs showing there?

Carl Jeffery: There were all kinds of medications included in there, I looked at several of them.

James Marx: We might want to keep an eye on the compounds.

Chris Shea: Could it be a simple compounded IV antibiotic?

Carl Jeffery: Yes, it could be. Two or more ingredients make a compound.

Beth Slamowitz: I asked some of the other states to see what other policies are in place. Alabama has a separate hospice PDL. Kansas requires a PA for all hospice patients. Delaware requires PA and a plan of care to be submitted. Some of the best practices for other states; 15 states do require prior authorization, mostly on the medical side. This helps address some of the conflicts of interests. The medical side is recommending adding some controls. For the pharmacy program, we have some recommendations.

Carl Jeffery: In the packet of handouts, there is a proposed PA sheet and proposed criteria. We are postulating that some of the prescribers for Synagis are specialists and may not be aware the recipient is on hospice. The first question is to make sure the prescriber knows the recipient is on hospice. The next question asks if the drug is related to the hospice diagnosis. The third asks if the medication is medically necessary. It prompts the prescriber to think through the process about if this is really necessary for this recipient. Then the last question is if the therapy provides prophylactic or curative treatment.

James Marx: Would this address using Harvoni or Hep C?

Carl Jeffery: That is our intent because these are tough decisions.

Mary Griffith: We are not really denying the service, we are denying who is paying for it. If we deny something, then the hospice will be responsible. If the recipient wants to pursue a curative treatment, then they could get out of hospice. There is no limit on when they can go in and out of hospice.

James Marx: Are hospice providers paid at a capitated rate?

Mary Griffith: It is a per diem rate, depending on what the service is.

Coleen Lawrence: They get an all-inclusive service in a bundled rate.

Beth Slamowitz: Originally, we looked at just over 20, but when we started looking at the data, we also wanted to include the pediatric patients.

Paul Oesterman, Chairman: For clarification, the agenda says over the age of 20. We will need to come back next time for the 19 and under group. It should be under 21.

Darrell Faircloth: Coleen was telling me about some of the characteristics of the EPSDT program and if they will override these criteria for purposes of your action today. For today, you can only adopt the criteria for over 20.

Mary Griffith: Keep in mind that Synagis still requires a PA for everyone. Because of that, these physicians do not know the recipient is in hospice.

Dave England: Would that be a question for the PA call center?

Carl Jeffery: There are not any criteria for that now, so that is not something they ask right now. That is one of the reasons we wanted to adopt this criteria.

Paul Oesterman, Chairman: To recap, we have the proposed PA criteria that apply to recipients over the age of 20. It includes the four points and would include authorization for 3 months. One question, on point B, the requested medication is not being used... it sounds like you eliminated the word "Symptoms" out of that.

Carl Jeffery: Right, it should be just to treat the terminal diagnosis.

Paul Oesterman, Chairman: We need a motion to approve the proposed criteria for recipients.

Dave England: Moved.

Michael Owens: 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 for medications used in the treatment of Hepatitis C.

Paul Oesterman, Chairman: The next agenda item, discussion and possible adoption of updated prior authorization criteria for the medications used in the treatment of Hepatitis C. Do we have any public comment?

Andrea Scherschel: This is Andrea Scherschel, I'm an MSL with Bristol-Myers Squibb. I wanted to give you some updated clinical data on Daklinza, SVR in cirrhotic patients. There was no benefit with extending therapy, but there was a benefit with adding ribavirin. We are waiting for a label update and this data will be included in the updated label. We will have FDA approval for co-infection, treatment with decompensated liver disease and people who are post-transplant. Do you have any questions?

Dave England: Looking at the minutes from the last meeting, we discussed how to address the new information from national groups. The criteria we have now need to be in place while this information is released and then go back and review it after the fact.

Coleen Lawrence: That's what we did last time. The clinical call center has the authority to use peer reviewed literature that is available at the time of the request. Based upon their current research, they have the authority to use current research based on peer reviewed literature.

Dave England: We could still leave what we have, we don't need to change what we have here until it is published.

Coleen Lawrence: We should include the language in the binder that talks about medically accepted indications so we have that reference.

Paul Oesterman, Chairman: On the proposed criteria, are there any changes to what we previously approved?

Carl Jeffery: It mirrors the most recent AASLD guidelines. The updated criteria are in the binders.

Darrell Faircloth: This is all new? This isn't red-lined.

Carl Jeffery: Yes, it has all been reworded; they started from scratch following the direction from the last meeting. The old criteria breaks it down by product, but this is broken down by genotype. These criteria will accommodate new agents as they come on the market.

Paul Oesterman, Chairman: The bottom line is we are following the guidelines, there shouldn't be many denials.

Carl Jeffery: If the recipient meets the criteria from the guidelines as outlined by the AASLD, there shouldn't be anything denied. A correction on the Daklinza quantity limit on the last page, for recipients who are on other inducers need a higher dose, they need two tablets per day.

Dave England: On 3.d., that should be one or two tablets.

Carl Jeffery: Maybe it could be more specific if the patient is on an inducer, then they can get two tablets per day.

Paul Oesterman, Chairman: Do we have a motion to approve?

Dave England: Moved.

Chris Shea: Second.

Oesterman, Chairman: We have a motion and second to approve the criteria with the amendment of up to two per day if patient is on a CYP 3A inducer for Daklinza.

Voting: Ayes across the board, the motion carries.

- b. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for tasimelteon (Hetlioz®).

Paul Oesterman, Chairman: The next action item is discussion and possible adoption of prior authorization criteria for tasimelteon or Hetlioz. Any public comment?

Carl Jeffery: This isn't a hugely used drug. We had one patient back in May. It is very specific population that this should be used for. In an effort to assure the correct recipients get this medication, we are proposing these PA criteria. It is intended for people who are totally blind to get their circadian rhythm. We talked about adding a therapeutic dose for the melatonin requirement.

Paul Oesterman, Chairman: Should there be a duration on the PA?

Carl Jeffery: That is a good question; I don't know how long someone is usually on this. I didn't look into the details regarding that person and their prescription. Typically our default duration is one year.

Paul Oesterman, Chairman: The package insert states the effect may not occur for weeks or months.

Carl Jeffery: I would kind of assume it is a long-term therapy.

Dave England: Is this really a therapeutic class of psychotropic?

Carl Jeffery: It is classified as a sedative hypnotic.

Paul Oesterman, Chairman: With these criteria, we are only approving for sleep/wake disorder, not major depressive disorder, but that may follow suit. It is being studied now. We need a motion to approve.

James Marx: Moved.

Chris Shea: Second.

Paul Oesterman, Chairman: We have motion and second to approve the criteria as presented with the inadequate response to at least four weeks of therapy to a therapeutic dose of melatonin or an adverse reaction or contraindication to melatonin.

Voting: Ayes across the board, the motion carries.

- c. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitors.

Paul Oesterman, Chairman: Our next agenda item is discussion and possible adoption of prior authorization criteria for proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitors. Do we have any public comment?

Sylvia Churchill: My name is Sylvia Churchill, I am a pharmacist from Washington State representing Amgen. I am here to talk about Repatha. Looking at the prior auth, I think everything looks appropriate. But I did have one concern. There is a requirement for high-intensity statin therapy, and that is appropriate, the label says we are to be given with a statin therapy that still need a decrease in their LDL levels. But what I have a concern with is the requirement to have patient on a three month trial of Zetia before being put on a PSCK9. If you look at our label, there is no mention of Zetia. If you look at Zetia, it only lowers the LDL by 10-15%, whereas PSCK9s lowered the LDL by a different mechanism and reduce LDL by 40-60% compared to the statin alone. The prescriber would be better off going right to a PSCK9 instead of having to try Zetia. The other requirement I question is it being prescribed by a cardiologist or lipid specialist. Only because this is a very safe drug and a lot of primary care and endocrinologists prescribe statins.

Paul Oesterman, Chairman: It is actually in consultation with a cardiologist or lipid specialist. Any other questions? Any other comments from the public?

Carl Jeffery: At the last meeting we talked about one product that was available. We updated the criteria to exclude the drug names. I will address the Zetia trial requirement. It makes sense because the guidelines have not been updated yet; the next step following statin therapy is to add Zetia. It is the next logical step.

Dave England: The current guideline is three months? If two weeks is acceptable, then I could live with that.

Carl Jeffery: I'm not sure what the guidelines state. I think it is hard to get the patient back after that amount of time, but we could make it a minimum of two weeks.

Paul Oesterman, Chairman: So we are changing this from three months to two weeks?

Carl Jeffery: If we just have a minimum of two weeks, then we can cover the real life scenario of patient's getting back to the prescriber in a short amount of time.

Dave England: I'll make the motion to accept.

James Marx: Second.

Paul Oesterman, Chairman: We have a motion and second to accept the criteria with the change from three month trial to a minimum of two weeks for ezetamide or Zetia.

Voting: Ayes across the board, the motion carries.

d. For Possible Action: Discussion and possible adoption of prior authorization criteria for colchicine (Colcrys®)

Paul Oesterman, Chairman: The next topic is the discussion and possible adoption of prior authorization criteria for colchicine. Do we have any public comment on this?

Carl Jeffery: It has been over five years since it has been reviewed by the Board. The criteria are limited to the familial Mediterranean fever or acute gout or chronic gout. We updated the criteria to add age and some criteria around chronic gout. The criteria are red-lined. There are specific criteria for patients wanting to exceed the quantity limits. Colchicine capsules have a different FDA approved indication, so they are called out separately.

James Marx: Isn't colchicine dosed to an effect? How does this recommendation go with that?

Dave England: That is for acute gout, dosed to diarrhea.

Carl Jeffery: The current quantity limit would take care of any acute attack and then treat prophylaxis if needed after.

Paul Oesterman, Chairman: Is there a difference between the tablets and capsules?

Carl Jeffery: No.

Paul Oesterman, Chairman: Is one being preferred over the other?

Carl Jeffery: No, this isn't a class on the PDL. The indication is the difference between the caps and tabs. The caps only have the chronic indication.

Dave England: I move we accept the criteria.

James Marx: Second.

Paul Oesterman, Chairman: Motion and second to accept the proposed criteria.

Voting: Ayes across the board, the motion carries.

e. For Possible Action: Discussion and possible adoption of updated prior authorization criteria for the medications used for the treatment ADD/ADHD.

Paul Oesterman, Chairman: Our next topic is the discussion and possible adoption of updated prior authorization criteria for the medications used for the treatment of ADD/ADHD. Do we have any public comment?

Carl Jeffery: Our intent is not to review all the criteria; we just want to review the combination of the long-acting agents. We have two long-acting products now that work well with stimulants, Intuniv and Kapvay. Our call center is running into an issue with requests for Intuniv and Adderall XR. Clinically it makes sense, but the call center

doesn't have the rules to approve it. Clearly we don't want two long-acting stimulants like Adderall XR and an extended methylphenidate. In the binder you have a chart showing how many are on multiple long-acting ADHD treatment. It breaks it down by age and number of claims. The current criteria are on page 105. We added on the first, "Only one long acting stimulant can be used at a time, a 30-day transitional overlap in therapy will be allowed."

Dave England: So they can use the two sustained release product for transition, but not concurrently.

Carl Jeffery: A transition from one long-acting to another will be allowed for transition. Under 'C', an age restriction was also added, 3 years for short acting and 6 for long-acting. And the quantity limits have also been updated.

Paul Oesterman, Chairman: Do we have a motion to approve the updated criteria for the ADD/ADHD agents?

James Marx: I'll move.

Chris Shea: Second.

Paul Oesterman, Chairman: In the therapeutic class is it "ADHD/ADD" or "ADD/ADHD," just for consistency? We just may want to make it the same throughout.

Voting: Ayes across the board, the motion carries.

- f. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for levalbuterol (Xopenex®)

Paul Oesterman, Chairman: Our next topic is the discussion and possible adoption of prior authorization criteria for levalbuterol or Xopenex. Do we have any public comment?

Carl Jeffery: We have Xopenex as preferred, and at our last P&T Committee meeting, a physician asked that we review the PA requirement. We brought this for review per his request. I don't have any suggestions for changes, but the Board can discuss. His idea was that there are fewer side effects with levalbuterol vs. albuterol.

Paul Oesterman, Chairman: It is available, just with a PA.

Dave England: Most literature I have read doesn't provide any difference in cardiovascular issues.

Paul Oesterman, Chairman: I like the criteria we have in place right now. If we are going to keep it the same, we don't need a motion or to vote.

- g. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for naltrexone (Vivitrol®).

Paul Oesterman, Chairman: Our next agenda item is the discussion and possible adoption of prior authorization criteria for naltrexone or Vivitrol. Do we have any comment?

Debra Profant: I'm Debra Profant, I am an employee of Alkermes. The criteria has a requirement for a naloxone challenge, and you are one of the only states with this requirement. Most other states have a requirement for the physician to go over the risks involved prior to use and then the on-going risks. There are some states that talk of the use of a drug-screen. The urine screen and the naloxone challenge can miss and give a false negative. The naloxone challenge is more invasive and is cumbersome for the physician.

Dave England: I saw some literature with some criticism on how it was tested to other treatments.

Debra Profant: That is true, the studies that have been done have been vs. placebo. This therapy is an antagonist; this is for a different patient population. The other therapies are more of a maintenance therapy. You will find about half of the population that would qualify for this therapy don't go on it. It is for highly motivated patients or patients with a court mandate. There are more studies being done.

Paul Oesterman, Chairman: What do we have from other states?

Carl Jeffery: I don't have anything from other states. There is a letter from Dr. Dixon saying the naloxone challenge is not in the best interest of her patients.

Paul Oesterman, Chairman: It looks like Dr. Dixon is offering two urine screens as an alternative to the naloxone challenge.

James Marx: I think what she is doing is not so much an alternative, these would already be done. The other point she makes is addicts are very afraid of going into withdrawal and will admit if they are under the influence at the time of the office visit. I think it is valid in what she is saying.

Paul Oesterman, Chairman: What we are proposing right now is the current naltrexone criteria would remain as-is, but remove the naloxone challenge.

Carl Jeffery: Right and I think this is consistent with the direction the state wants to go with a focus on addiction treatment.

James Marx: I think we should also recommend some routine monitoring.

Carl Jeffery: Like what we do with buprenorphine products, not so much of a mandate, but recommendations for routine monitoring.

Paul Oesterman, Chairman: So we are proposing we eliminate 1B, but then add a new 1D, that routine urine screens/monitoring is recommended.

Carl Jeffery: Do you want to clarify what you are testing for the urine screen, you're looking for opioids, do you want to clarify that?

Paul Oesterman, Chairman: The revised criteria, eliminating the naloxone challenge and adding that routine opiate urine screen/monitoring is recommended.

Darrell Faircloth: No initial urine test?

Paul Oesterman, Chairman: By the time they are in the office, they are ready for treatment. Do we have a motion to approve?

Dave England: So moved.

James Marx: Second.

Voting: Ayes across the board, the motion carries.

6. Public Comment on any DUR Board Requested Report

Paul Oesterman, Chairman: Now we have our normal requested reports. Do we have any public comment?

7. DUR Board Requested Reports

a. Cumulative acetaminophen report

Carl Jeffery: The first report is the acetaminophen dosing, adding up the cumulative dose. I'm surprised there are so few people over 4 grams per day.

Paul Oesterman, Chairman: 234,000, the 8th one down, that seems like still a lot of hepatotoxicity.

James Marx: The four gram limit is really just for short term, not for the rest of your life. It really should be limited to 2.6 grams per day.

Carl Jeffery: We do have the single products limited to 3 grams per day, but if they are on multiple products, then it could be exceeded.

Dave England: Do we have the authority to set to 2.6 grams long-term vs. acute. Is that in our jurisdiction?

Carl Jeffery: From a claims standpoint, those are hard to catch. You may have some people who change therapy.

Paul Oesterman, Chairman: I think it would be interesting to drill down those patients who have greater than 50,000 mg, look to see if they are taking chronically. Don't look

at the onetime fills, but look at the days' supply filled. There are not very many, it looks pretty promising. What was the time frame?

Carl Jeffery: Three months.

Paul Oesterman, Chairman: So someone with a 90 day supply is getting it chronically. Can we get a report on the higher daily use? Anybody have anything else? The next report is the anticonvulsant.

b. Anticonvulsant utilization trending report

Carl Jeffery: The Board asked to look at the overall anticonvulsant, I think really looking at gabapentin, and it is no surprise it is at the top of the list. I think the other products fall in line.

Paul Oesterman, Chairman: Do we have any way to match up with a diagnosis of seizure disorder vs. peripheral neuropathy?

Carl Jeffery: Sure we can do that; we can get some claims from the medical side. Just for the gabapentin?

Paul Oesterman, Chairman: I would say gabapentin, Lyrica and divalproex. And then we have the naloxone utilization report.

c. Naloxone utilization

Carl Jeffery: I think we want to keep an eye on this. The legislature required us to put naloxone on the PDL as preferred. A nasal spray was recently made available and there was a news report about it being made available at the high schools. You can see the claims from the physician's office. There were no claims for the Evzio. We don't have any PA criteria on it.

James Marx: I think it may be coming from the managed care.

Carl Jeffery: Speaking of hospice, we have a hospice patient getting Vivitrol. All the other oral naltrexone are fee for service and a few long-term care.

8. Public Comment on any Standard DUR Report

Paul Oesterman, Chairman: Now moving to our standard reports. Any public comments?

9. Standard DUR Reports

Carl Jeffery: The first page is top 10 by paid amount. We usually have the top few jumping around, antipsychotics, hep C and hemophilia treatments. Those are always competing for number one. The Hep C treatments seem to have plateaued. Generic Abilify is now available, but it is non-preferred, the brand is still preferred. The next is

listed by claim count, opioid analgesics are number one, anticonvulsants are number two and antidepressants are number three.

Paul Oesterman, Chairman: The count is fairly consistent quarter to quarter.

Carl Jeffery: Starting on the third page is broken down more specifically. We can get a better idea of what drugs are driving the numbers.

Paul Oesterman, Chairman: on the claim count, what is included in the central muscle relaxants?

Carl Jeffery: That would include all the skeletal muscle relaxants.

Paul Oesterman, Chairman: Looks like the claim counts are consistent. What about the membership count?

Beth Slamowitz: It is increasing, up to about 635,000 for everything

Carl Jeffery: Fee for Service is about 150,000. And that is holding pretty steady, and you are seeing the numbers just from the fee for service. You usually see a spike around January in the membership count. On the top 50, Harvoni and Abilify and hemophilia hold the top. The hemophilia is hard to manage and takes some special case management. If the Board has some ideas how to corral some of the costs, please let us know what you think. It is tough class to manage.

Paul Oesterman, Chairman: Where do we stand on the combination of the beta-blocker inhalers with steroid? Like Symbicort or Breo and Advair. Are any preferred?

Carl Jeffery: Yes, this is a popular class, we frequently present it to the P&T Committee. Advair still holds the majority of the utilization; we can look at the class if you want.

Paul Oesterman, Chairman: Yes, let's look at that class.

Michael Owens: Yes, are we treating Hep C by diagnosis? If a patient has a diagnosis of Hep C, that isn't enough for some of the other programs; they require some changes with the liver. I try to tell the patients that not everyone may need to get treatment.

Coleen Lawrence: The guidelines are the norms for the other Medicaid agencies; I'm not sure what other commercial plans are doing. We have Federal regulations we have to abide to. I don't know what the other commercial plans are doing.

Michael Owens: I thought the other Medicaid programs are little more restrictive.

Coleen Lawrence: There was a release from CMS regarding the guidelines for Hep C and how we set our policy. It was a warning letter to make sure we are using clinical guidelines, not just looking at cost, using best practice and those types of things.

Carl Jeffery: There are some states with criteria such as drug tests, and some F scores for cirrhosis.

Coleen Lawrence: We talked about this at the beginning and presenting some options. CMS came back later and now some states have to change.

Carl Jeffery: The commercial payers do not have the same restriction.

Michael Owens: I wonder why, of the plans, we are the least restrictive? That is what it seems like to me. And I'm not sure where the other Medicaid programs are.

Coleen Lawrence: Make sure you are not comparing us to Federal or commercial programs. If social determinants rather than best practices, the Medicaid MCOs have to come back now and take another look at their criteria, but our criteria is ok.

Paul Oesterman, Chairman: In terms of other reports, could we look again at short-acting insulin with or without basal insulin. On the next set of reports, on the insufficient duration alerts, a couple of the antibiotics, for Invanz or sulfamethoxazole/trimethoprim, there is a message for insufficient days. Looking at April to June.

James Marx: There are some one day treatments.

Paul Oesterman, Chairman: Right that is what I was looking at, should we consider changing the days.

Carl Jeffery: There is a minimum of five days, and these are just messages to the pharmacy to make sure the dose is correct. I doubt very many pharmacies get these messages.

Chris Shea: So the total reversed, is that the number reversed because of the message?

Carl Jeffery: We can't tell why they were reversed, it could be from the message or it could be because the member never came to pick it up at the pharmacy.

Paul Oesterman, Chairman: Am I correct at assuming our promethazine claims are at the bottom?

Carl Jeffery: We can take a look at it for the next meeting.

Paul Oesterman, Chairman: Can we do all the liquid narcotic cough suppressants?

Carl Jeffery: Sure, because we limited a few others as well.

6. Closing Discussion

Paul Oesterman, Chairman: Anybody have anything else? Are there any comments from the public?

Laurie Squartsoff: Laurie Squartsoff from the Department of Health and Human Services. I would like to suggest a future topic and that is the health care guidance program and how you can use the program maybe for the hemophilia patients. Secondly regarding the discussion of naloxone and aligning the policy with the legislative regulation passed at the last session, look at how chronic opioid addiction is addressed in the state.

Coleen Lawrence: This Board has had a couple presentations now for the healthcare guidance program. They have been working with exchanging data, but we can bring it back with the hemophilia population in the future. I also want to let you know, but we will be doing something with the transgender medications. We will probably do something administratively, looking at peer-reviewed literature, we will be reworking at allowing the diagnosis to go through for hormone therapy. Right now, it stops at the counter. Obviously nationally this is a large issue and we want to make sure we are not limiting access to care.

James Marx: Will there be a meeting to review that?

Coleen Lawrence: It depends on the timing, but everything will be supported on peer-reviewed literature.

Paul Oesterman, Chairman: Our next meeting is scheduled for April 28th, same time, same place. The meeting is adjourned.

The meeting is adjourned at 7:40 PM.