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

Date of Meeting: Thursday, July 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.; David England, Pharm.D.

Committee Members Absent: Jeffrey Zollinger, DO; Chris Shea, Pharm.D.

Others Present:

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

HPES: Beth Slamowitz, Pharm.D.

OptumRx: Carl Jeffery, Pharm.D.

Others: James Osborne, GSK; Coleen Lawrence, Moxy Health; Jeanette K Belz, NV Psychiatry Assn; Laura Hill, Abbvie; Karen Nguyen, Allergan; Sean McGarr, Allergan; Contessa Fincher, Teva; Catherine O'Mara, NSMA; Jennifer Lauper, BMS; Melissa Walsh, Novartis; Lori Howarth, Bayer; Stephen Edney, MD

Others On Line: Mark Schwartz, GSK; Indira Mahidhara, Amerigroup; Altamit Lewis, Amerigroup; Chris Standfield, Supernus; Brian Brooks, Amerigroup; Betty Chan, Gilead; Kathleen Conaboy; Catherine O'Mara; Maya Zamir, Amerigroup; Jill Sugg, UCB

1. Call to Order and Roll Call

Meeting called to order at 5:22PM

Roll Call:

Carl Jeffery

James Marx

David England

Michael Owens

Paul Oesterman, Chair

Darrell Faircloth

Beth Slamowitz

Shannon Sprout

Mary Griffith

2. Public Comment on Any Matter on the Agenda

Paul Oesterman, Chair: Are there any general public comments. None.

3. Administrative

- a. **For Possible Action:** Review and Approve Meeting Minutes from April 28, 2016.

Paul Oesterman, Chair: We will start with the administrative section. I will ask for approval of the April 28, 2016 meeting minutes.

James Marx: I move for approval.

David England: Second.

Voting: Ayes across the board.

- b. **Status Update by DHCFP:**

Paul Oesterman, Chair: Our next item is an update from the Department.

Mary Griffith: There isn't a lot that is new. We have final rules from CMS for MCOs, final rules for outpatient drugs, and another final rule for durable medical equipment and there are a couple things coming from CMS. For the covered

drugs, we have to document in our State Plan how we are going to pay for 340B, how we are going to price our factor drugs and our physician administered drugs. Other than that, we don't have as much work as other states because we have done the NADAC pricing and dispensing fee survey. I'm still updating the policies.

Paul Oesterman, Chair: Any policy changes from January and April?

Mary Griffith: I'm still working on them.

4. Clinical Presentations

- a. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for pediatric use of gonadotropin-releasing hormone (GnRH) analogs.

Paul Oesterman, Chair: We will start on the clinical discussions. We are going to defer item F. until the next meeting. Our first item is a discussion of pediatric use of gonadotropin-releasing hormone analogs. Do we have any public comment? Hearing none, Carl do you want to present this information?

Carl Jeffery: This was brought to review because we talked about the medications used for transgender treatments at the last meeting. This drug came up as something being used for delaying puberty or used for transgender use. But we saw some questionable use in female patients with autism. There were some articles about this being used to delay menses and puberty in autistic youth. Starting on page 26, the usage is broken down by male and female. The megestrol doesn't concern me, but some of the other ones look a little funny.

Paul Oesterman, Chair: Do we know if these are ordered by an endocrinologist.

Mary Griffith: I think they were mostly pediatricians.

Carl Jeffery: We looked at diagnosis.

Mary Griffith: A lot of them did not have anything with an FDA approved use.

Carl Jeffery: We would expect to see precocious puberty, but we only saw only autism spectrum disorder.

Paul Oesterman, Chair: Is there any prior authorization criteria now?

Carl Jeffery: No. And one thing I wanted to update with the proposed criteria is to limit it to under 18, let the adults continue getting this without prior authorization.

James Marx: So what diagnosis are we going to use?

Carl Jeffery: The proposed criteria lists idiopathic or neurogenic precocious puberty, endometriosis, uterine leiomyomata and prostate cancer.

James Marx: This is just for the Lupron?

Carl Jeffery: We have it for the Eligard too.

Paul Oesterman, Chair: We have the proposed authorization criteria, but we are adding that this is only for patients under 18.

James Marx: So we are not talking about the other medications we discussed at the last meeting?

Carl Jeffery: No, we are ok with that one. There is no gender edit right now with this.

Paul Oesterman, Chair: We need a motion to approve the amended proposed criteria for ages under 18.

David England: So moved.

James Marx: Second.

Carl Jeffery: To make it clear for the record, this is for the amended criteria to only include patient under 18.

Paul Oesterman, Chair: Right, call for a vote for the amended criteria

Voting: Ayes across the board, the motion carries.

- b. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for medications used to treat Irritable-Bowel Syndrome.

Paul Oesterman, Chair: Our next topic is the discussion and possible adoption of prior authorization criteria for medications used to treat irritable bowel syndrome. Do we have any public comment?

Karen Nguyen: I'm Karen Nguyen with Allergan. Today I will be talking about Linzess and Viberzi. I am providing the national treatment guidelines from the AGA. Linzess was the only drug to give strong recommendations. Viberzi was not available at the time the guidelines were written so are not included.

Carl Jeffery: This is a carryover from the last meeting. We passed some criteria for Viberzi, but this criteria include IBS-D and IBS-C. The proposed guidelines go through the more standard therapies even though as Karen pointed out, they may not be as effective. But by the time patients get to these drugs, they have likely tried all of these anyway.

David England: Karen, I just want to clarify. Your testimony suggests these other agents are not the best, but would there be any damage to the patient by prolonging the time to get these other agents?

Karen Nguyen: As far as worsening the disease, no. But as far as quality of life, there would be an impact, lower productivity. Studies show that patients failing initial treatment cost more than patients who get the proper treatment up front. It does impact patient's lives when they have to go to the bathroom multiple times a day or they are soiling their underpants. In essence, there is an indirect impact. A lot of these patients have tried everything available over the counter.

Paul Oesterman, Chair: Looking at the criteria, the IBS-D does not have the laxative failure for step therapy.

Karen Nguyen: But you are requiring antidepressants and antispasmodics. The guidelines recommend not using SSRI's because there is no evidence. The TCA's often have anticholinergic side effects, and they don't address all the effects for IBS.

James Marx: I think we should basically remove those criteria. There is a cost with quality of life issues, and we are requiring treatments that are not real effective in most cases and have significant side effects.

Paul Oesterman, Chair: You recommend we remove C.1. and D.3.?

James Marx: Correct, that would be my proposal.

David England: Since we now have better medications, we wouldn't want to eliminate the availability of these. Just because these are not included in the criteria, that doesn't mean they can't be used.

James Marx: No, they could still be used. We are not excluding them.

Paul Oesterman, Chair: We need a motion to approve the modified criteria with removing C.1. and D.3.a. and b.

David England: Moved.

James Marx: Second.

Voting: Ayes across the board, the motion carries.

- c. **For Possible Action:** Discussion and possible removal of prior authorization criteria for duloxetine.

Paul Oesterman, Chair: Our next agenda item is the discussion and possible removal of prior authorization criteria for duloxetine. Is there any public comment?

Carl Jeffery: Duloxetine has been on the market for a long time. I think this criteria has been here for years, so I wanted to have the Board review it. Similar agents do not have this criteria and the criteria may be a roadblock for patients from getting effective therapy.

Paul Oesterman, Chair: So we are proposing the removal of the PA criteria for duloxetine.

Carl Jeffery: Just to clarify, it will still require PA for the psychotropic criteria for children and polypharmacy criteria for children under 18.

James Marx: I move for the removal of the prior authorization for duloxetine.

David England: Second.

Voting: Ayes across the board, the motion carries.

- d. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for the medication class Antiasthmatic Monoclonal Antibodies.

Paul Oesterman, Chair: Our next agenda item is the discussion and possible adoption of updated prior authorization criteria for the medication class antiasthmatic monoclonal antibodies. Do we have any public comment?

James Osborne: I'm James Osborn, a health outcomes liaison with Glaxo Smith Kline. I want to make a few remarks about Nucala. I am providing comments on the covered indication, efficacy numbers in the binder information, and warnings from the manufacturer. Item C. in your proposed criteria, in our clinical development sputum eosinophilia did not differentiate responders and non-responders. That is why we chose blood eosinophils levels. The request we have is for items F. and G., the requirement for the second generation antihistamine and a leukotrinine receptor antagonist. We defined severe asthma as patients on high dose corticosteroids plus a second controller who were inadequately controlled. These were not the allergic asthmatics per se. We recommend you change the requirements in F. and G. to high dose corticosteroids plus a second controller such as long-acting beta agonist, a leukotriene agonist, or we had some studies with people on theophylline.

David England: You recommend removing F. and G.?

James Osborne: I would replace F. and G. with high dose corticosteroid plus a second asthma controller as an appropriate way to identify patients with severe asthma. That is the severe asthma part, and the blood eosinophil is the other part to identify the phenotype.

Contessa Fincher: I'm Contessa Fincher, a medical outcomes liaison for Teva pharmaceuticals. I wanted to discuss Cinqair, a similar product to Nucala. It is

indicated to help patients who are uncontrolled on their standard of care and they will have Nucala added to their maintenance therapy. The main issue is these severe asthmatics need to have some kind of eosinophilic phenotype. I agree with the GSK speaker on F and G, the mechanism of action on these monoclonal antibodies. If there are not a lot of differences, the eosinophil count in the criteria of greater than 150 cells, the number of eosinophils in our trials was 400 cells and above and our researchers found the gold standard of 400 cells because that resembled what the sputum test would be. But physicians don't really use the sputum test, they use the blood eosinophil count. It is cheaper and easier to do. So we are fine with the count being more than 150 as long as the physician finds out if the patient has severe asthma or not because that would be the indication to use these products. The exacerbations are not mentioned in the criteria, but that is ok but that is a slight difference. If the patient in the prior year had more than one asthma attack, then they entered our trial, more than two then they entered the Nucala trials. Our efficacy is similar between the drugs. We decreased asthma exacerbations by 50-59% in two studies. Another difference is the safety, for our product, the most common adverse events were upper respiratory tract infection, pharyngitis. But we have a black box warning, there were three cases in total for anaphylaxis, but it is a risk. The mode of administration is IV, and Nucala is subq. It needs to be given by a health care professional. Both products decrease hospitalizations. I ask that F. and G. doesn't need to specify any kind of failure because they are already the worst of the worst. They don't need to fail anything as long as they have the high eosinophil count.

Paul Oesterman, Chair: Do we have any usage data at this point?

Carl Jeffery: There is some utilization, it is in the binder on page 50, the only one we have is Xolair. There is no utilization of the other products.

David England: So we are looking at changing F. and G. to patients that are already on their current products.

Contessa Fincher: We stated it as they are uncontrolled on their standard of care.

Carl Jeffery: Does the Board need to identify what is the minimum standard of care? Like high dose corticosteroid and a secondary agent?

Paul Oesterman, Chair: If we were to consolidate F and G to say something to the effect the recipient must be uncontrolled on current therapy included high dose inhaled steroids and a/or a secondary asthma inhaler.

James Marx: I propose that as a motion.

Paul Oesterman, Chair: I want to go back to the Zostavax that was mentioned, should we include that in the criteria for the Nucala?

James Osborne: If I could comment, I would ask the committee, can your members get the Zostavax vaccines? There are situations based on age, it may be

difficult to get. The package does not require it, but recommends the physician consider if the patient should receive it prior to starting Nucala. The indication is 50 and older.

Carl Jeffery: Maybe add a recommendation that Zostavax be considered.

David England: It could be any other infection that should be addressed before going on this product.

James Osborne: That is what our label says, the physician should consider before starting Nucala.

David England: We should get any other infection under control first as far as the class goes.

James Marx: Did you see any other type of infection like histoplasmosis or anything?

James Osborne: We didn't see anything like that. The only two opportunistic infections we saw were the two herpes zoster.

Paul Oesterman, Chair: Right now we have the proposed criteria with the modification of F. and G. Also, I wonder if we shouldn't eliminate the elevated sputum eosinophils out of C. Just keep with the blood eosinophil greater than 150.

David England: I like what we have done so far. I would like to have something for opportunistic infection, but what would be good language?

Carl Jeffery: I think some of this you just have to put back on the prescriber, they are taking the responsibility when prescribing this medication.

Paul Oesterman, Chair: Maybe it could be as simple as documenting vaccine status, they don't have to do it.

Michael Owens: All these prescribers will be allergists or pulmonologists or immunologists. They should have a pretty good idea of what to do.

Paul Oesterman, Chair: We have proposed criteria with three changes. One is the elimination of the sputum eosinophils, second is the F and G to read, "The recipient must be uncontrolled on current therapy including high dose corticosteroid and/or a secondary asthma inhaler." And then documentation of vaccine status.

David England: So moved.

James Marx: Second.

Voting: Ayes across the board, the motion carries.

Mary Griffith: Can you summarize that one more time for me?

Paul Oesterman, Chair: We are going to eliminate C, the elevated sputum eosinophils. F. and G. is now combined to read, "The recipient must be uncontrolled on current therapy which includes an inhaled high dose steroid and/or a secondary asthma inhaler." And then "I.", documentation of vaccine status.

- e. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for the medication class Hepatitis C direct-acting antivirals.

Paul Oesterman, Chair: The next item is discussion and possible adoption of updated prior authorization criteria for the medication class Hepatitis C direct-acting antivirals. Do we have any public comment?

Laura Hill: My name is Laura Hill and I am with Medical Affairs at Abbvie. I have a couple comments for Viekira Pak. The PA criteria looked accurate. A couple things for consideration. Abbvie had an extended release product recently approved called Viekira XR. This is given as three tablets once daily with a meal. I have information on formulation, indications and warnings. The second part, the supplemental documentation, the Turquois 3 study was not included in the document, but is captured in the proposed criteria.

Paul Oesterman, Chair: Anyone else for public comment.

BC: This is Betty Chan for Gilead Sciences. I just want to make myself available for any questions. A new product was recently approved, Epclusa, but didn't make it on the agenda.

Paul Oesterman, Chair: Thank you. What do we have for proposed revisions?

Carl Jeffery: We have another medication, so this will come back for the next meeting. The updated criteria with the new Zepatier product included. There are two sets of criteria that look very similar. The redlined version starts on page 71. That shows the changes we have added since the last time this was reviewed by the Board. The utilization numbers are also included. The use has leveled off. Still Harvoni is the favorite, they are all listed as preferred and the criteria is pretty fair for all products. The updated criteria takes into account a few additions including Zepatier, starting on your page 80. These criteria follow the AASLD criteria.

Paul Oesterman, Chair: This just keeps growing and becoming a bigger book. Is there a way to consolidate this for the call center?

Carl Jeffery: I don't think they have too many other issues with it, I think it is going pretty well.

Paul Oesterman, Chair: We have the revised prior authorization criteria, it will be coming back at the next meeting with at least two additions.

Carl Jeffery: If there is a way to narrow down the changes. We talked about using verbiage for following AASLD guidelines.

Paul Oesterman, Chair: Do we have a motion to approve the current proposed criteria updates?

David England: Moved.

James Marx: Second.

Voting: Ayes across the board, the motion carries.

Paul Oesterman, Chair: The next agenda item will be deferred to the next meeting.

- f. **For Possible Action:** Discussion and possible adoption of prior authorization criteria and/or quantity limits for the medication class short-acting opioids and opioid agonists used for the treatment of pain.

5. **Public Comment on any DUR Board Requested Report**

Paul Oesterman, Chair: Next is the DUR Board requested reports. Do we have any public comment on the reports?

6. **DUR Board Requested Reports**

a. **Hepatitis C – 14 day trial compliance.**

Paul Oesterman, Chair: The first is the Hepatitis C – 14 day trial compliance.

Carl Jeffery: These are recipients who have received less than 56 days of therapy. To me that is not a full therapy for any approved products. There is a chance these recipients could have moved to a different plan or passed away. We implemented a requirement to start with 14 days of therapy before getting the full month on subsequent fills.

Paul Oesterman, Chair: Looking at page 93, the last Harvoni, there are two numbers below that.

Carl Jeffery: Yes, in May they got a 14 day supply and then April they got a 28 day supply.

Paul Oesterman, Chair: Ok, thanks. Is it possible to find out how many patients get the initial 14 day supply vs. the patients that get at least on more fill?

Carl Jeffery: Yes, the first page starts with members getting only 14 days and then not getting any more fills.

Paul Oesterman, Chair: I think what we really want to see is what happened, why they didn't complete the therapy.

Carl Jeffery: I'm not sure how we would gather that information. We would have to call every prescribers office.

James Marx: Are we doing letters with issues and concerns? Make it easy to respond by email or fax.

Carl Jeffery: Like a retro-DUR for patients that get a 14 day supply and then never fill it again? Send a letter to the prescriber's office asking for an explanation. I don't know what the concern with resistance is here, but it could be an issue in the future.

Paul Oesterman, Chair: That is our follow-up, we will do a retro-DUR.

b. Long-acting steroid inhaler combination utilization correlated with emergency department visits and short-acting rescue medication utilization.

Paul Oesterman, Chair: The next report is long-acting steroid inhaler combination utilization correlated with emergency department visits and short-acting rescue medication utilization.

Carl Jeffery: I didn't get the chance to get the ER data in the report. So what you have is the steroid inhaler data and rescue inhaler use. We did take all the patients getting these medications, and had the medical claims team and they looked for ER visits. They did not find any ER visits for members who were on these medications. But they did find about 1400 patients with ER visits with a diagnosis related to asthma exacerbations. I didn't get the chance to take those 1400 patients to see what therapy those people were on.

David England: We had 1400 members on what?

Carl Jeffery: No, the 1400 that had ER visits that were not listed on the report getting long-acting steroids. We didn't have matching members on the reports.

Paul Oesterman, Chair: For follow-up for next time, can we get that correlation?

Carl Jeffery: Sure, we can put that together.

c. Utilization of short-acting insulin without long-acting/basal insulin.

Paul Oesterman, Chair: Our next report is utilization of short-acting insulin without long-acting/basal insulin.

Carl Jeffery: This is a redo of the report that was presented last time. We are still looking at about 1200 members in the last nine months.

David England: Any way you could tie in A1c values?

Carl Jeffery: We don't have access to lab values.

Paul Oesterman, Chair: What about ER visits for hypoglycemic events for patients on long-acting insulin without a short-acting?

Carl Jeffery: Beth, is that something you think we could pull?

Beth Slamowitz: With an actual diagnosis code, we could pull claims that have something similar. We don't have access to medical records or lab values.

Carl Jeffery: It would have to be the primary diagnosis on the ER visit.

David England: Even though they are on their insulin, the A1c is the acid test for if it is working. Without that, even ER visits, you want to know what the A1c was for the ER visit.

Paul Oesterman, Chair: In this day and age, what is it going to take to get access to medical records?

David England: Without lab values, we have the pie crust but no filling.

Carl Jeffery: Right, it would be great to have some outcomes data too.

David England: I saw a CMS email talking about their data being made available for meta-analysis studies. You could use their data to pull your own studies. It seems like Medicaid should be able to do the same thing. We should have access to our own data. It will be interesting to see how this works out.

d. Proton pump inhibitors and complications/adverse effects.

Paul Oesterman, Chair: Next we have the report on proton pump inhibitors and complications/adverse effects.

Carl Jeffery: I don't have access to the adverse events or complications. A lot of these are not severe enough to go to the ER, so they would likely report it to their prescriber. The binder has the utilization numbers, which mirrors what is on our preferred drug list.

Paul Oesterman, Chair: Maybe we can modify the request to see if patients are having to change from one proton pump inhibitor to another.

Carl Jeffery: But we're not going to know why they are changing.

James Marx: My concern is we should be looking at admissions related to a vascular event, like stroke, MI, Diabetic peripheral vascular disease. We don't really need to have a diagnosis. If someone comes for MI, gastritis isn't going to be the primary diagnosis.

Beth Slamowitz: The specific primary diagnosis for admission can be done.

James Marx: My thinking is to compare this population vs. the population that is not on a PPI.

David England: It would be interesting to see how long these people have been on these agents and how many have progressed to esophageal cancer.

Beth Slamowitz: We would only have a diagnosis for the ER visit, we may not have it available for regular doctor office visits.

Paul Oesterman, Chair: I think one would be esophageal cancer, start there. If we look at a year back.

e. Long and short-acting opioid utilization.

Paul Oesterman, Chair: Are we going to cover the last topic of long and short-acting opioid utilization?

Carl Jeffery: Yes, I think it is ok to discuss since this is an ongoing report. This chart is by days supply, we have the top drugs with hydrocodone and oxycodone. The first long-acting agent is the fourth one down.

David England: Is it possible to separate the long and short-acting?

Carl Jeffery: Yes, if you look back at page 90, there were some reports showing just short acting products. It is sorted by total quantity?

David England: People still use meperidine? Is this the oral tablet?

Carl Jeffery: Yes, I limited it to oral.

Paul Oesterman, Chair: I would think dental is using this most. Suboxone, do we know if that is being used for pain? You might be able to break that down by DEA.

Carl Jeffery: The problem is the pharmacy submits the NPI, not the DEA, so we don't know which one they are using. There is one NPI and they could have multiple DEA numbers.

James Marx: Is the oral fentanyl on here too?

Carl Jeffery: Yes, it should be on the back page. We don't get a lot of claims for this. On page 89, I took the top three drugs and looked at multiple product formulations. We have 3 recipients that are getting 6 different formulations.

Paul Oesterman, Chair: We may want to consider them for the lock-in program. We will be addressing this next time. Any other comments on the requested reports?

7. Public Comment on any Standard DUR Report

Paul Oesterman, Chair: Is there any public comment on our standard reports?

8. Standard DUR Reports

Carl Jeffery: These are the same reports but updated for the new quarter. The antipsychotics and blood factor products bounce back and forth. The first one is by paid amount, and the second is by claim count. Nothing pops out to me on these reports.

Paul Oesterman, Chair: Our anti-hemophilia products have always been on the list, there is a new single immunization that is coming through the FDA. I'm sure that will come up on a future meeting. When did aripiprazole go generic?

Carl Jeffery: Maybe a little over a year ago, but we still have the brand preferred.

Paul Oesterman, Chair: So this is a skewed number,

Carl Jeffery: The pharmacy paid amount will be higher than what it would be otherwise.

Paul Oesterman, Chair: Looking at the fourth quarter, tobramycin, there were 78 claims. Was that the inhaled Tobi or the parenteral?

David England: That is just a 10 day supply.

Carl Jeffery: If I had to guess, I would say it was the inhaled tobramycin used for cystic fibrosis. We have run the numbers for our CF kids and I think this is in line.

Paul Oesterman, Chair: In terms of claim counts, it seems very consistent. The top five really don't change much.

Carl Jeffery: Synagis drops off in quarter 2, but we will see it again on the coming quarters as the season picks up again in November.

Paul Oesterman, Chair: Pro-DUR and Retro-DUR, what do we have?

Carl Jeffery: The Pro-DUR is listed.

Paul Oesterman, Chair: On page 126, number 6 and 7, what is the difference between these two? Spironolactone and Lisinopril? Why is that showing up twice? Same with 2 and 4.

Carl Jeffery: That is a good question, I'm not sure. Maybe different NDC's or strengths.

Paul Oesterman, Chair: How are we doing with the promethazine DM? It looks like under age 4...

Carl Jeffery: We looked at the other promethazine, but we didn't look at the DM product. The DM is becoming a popular street drug. That is something worth looking at. And guaifenesin, high doses can be abused. The only thing left is the retro-DUR handout. They did opioids and benzos with some interesting results. There is an overview and the results.

James Marx: I think the issue with that, is the patients that get in trouble are new to the regimen. The risk is pretty low for patients on this long-term.

Paul Oesterman, Chair: I would ask the Board members to take notes on this. I think it will be relevant for our next meeting.

Carl Jeffery: We are always looking for other retro-DUR ideas if anyone has any ideas. We have the Hep C therapy with the 14 days compliance.

9. Closing Discussion

Paul Oesterman, Chair: Anybody wish to address the Board?

Mary Griffith: Before we adjourn, we talked about moving the meetings back to days. What do you prefer?

Paul Oesterman, Chair: What we have been doing works for me.

James Marx: Doesn't really make a difference to me.

David England: We switched to the evenings to get better participation.

James Marx: I think if we want to increase physician involvement, the evenings are easier.

Mary Griffith: The next meeting we will have the annual DUR report draft.

Paul Oesterman, Chair: What is the date of the next meeting?

Carl Jeffery: October 27, 2016.

Paul Oesterman, Chair: We will adjourn the meeting. Thank you.

Meeting adjourned at 6:53PM.