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

Date of Meeting: Thursday, October 27, 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.; Jeffrey Zollinger, DO; Chris Shea, Pharm.D.

Committee Members Absent: David England, 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: Coleen Lawrence, Moxy Health; Joe Schreck, Allergan; Dave West, United Therapeutics; Jin Nguyen, AZ; Kerry Kostman, AZ; Sandy Sierawski, Pfizer; Ann Nelson, Vertex; James Kotusky, Gilead; Sal Lofaso, Horizon; Elyse Monroy, Office of the Governor; Jeanette K Belz, NV Psychiatric Assn; Brian Evans, The Perkins Co; Kerry Bonilla, AZ; Gin Yun; AZ; Liz MacMenamin, RAN

Others On Line: Altamit Lewis, Amerigroup; James Riske, Wellpoint; Laura Hill, Abbvie; Saiza Elayda; Bruce Smith, GSK; Chris Stanfield, Supernus; Mark Schwartz, GSK; James Maloney, Optum

1. Call to Order and Roll Call

Paul Oesterman, Chairman: We will call the meeting to order. Please limit your presentation to 5 minutes. We will start by asking for public comment before we get into the agenda. If you do see the item on the agenda that you want to speak about, you can speak when we get there.

James Marx

Jeff Zollinger

Michael Owens

Paul Oesterman, Chairman

Darrell Faircloth

Beth Slamowitz

Shannon Sprout

Mary Griffith

Carl Jeffery

2. Public Comment on Any Matter on the Agenda

Paul Oesterman, Chairman: Do we have any public comment? Do we have anybody on-line?

Carl Jeffery: Yes, there are a few people.

3. Administrative

- a. **For Possible Action:** Review and approve meeting minutes from July 28, 2016.

Paul Oesterman, Chairman: The first item is the review of the minutes from the July meeting. I have one question in regards to the final rule from CMS, where are we with that.

Mary Griffith: We are still in the process of working on them, we haven't hit the deadline yet. But we are working in getting the SPA submitted. CMS said we were one of the more efficient States they have worked with.

James Marx: I move for approval as submitted.

Michael Owens: Second.

Voting: Ayes across the board, the minutes are approved.

b. Status Update by DHCFP

Paul Oesterman, Chairman: Our next agenda item is the status update from DHCFP, in particular the Governor's Summit on Prescription Drug Abuse. A number of people in this room were fortunate enough to attend. Mary, I will let you give your update.

Mary Griffith: The Governor's Summit on Prescription Drug Abuse Prevention was held on August 31, and September 1. I was lucky enough to attend, Shannon and Beth also attended. Paul Oesterman and Dr. Marx also attended, we had representation from Medicaid and the Board. It was an excellent conference, I feel privileged just to attend. It included a multitude of stake holders including physicians, law enforcement, pharmacists, insurance companies and other State agencies, behavioral health agencies. It is going to take a collaborate effort for us to prevent any more prescription drug abuse or even to get a handle on it. This was encouraging because from my perspective, the first step to change is acknowledging there is a problem, and I think that is what we are doing with the Summit.

The next item was the prescription drug opioid abuse workshop that was held on October 20th. There are copies of the presentation in the back. A lot of the things were discussed, some of them were the CDC guidelines for prescribing opioids for chronic pain. Some of the other things discussed were the education of providers, drug testing policy criteria, determining the cause of pain before treatment with opioids. This is an on-going discussion that we will be continuing with our Board meetings for the foreseeable future and with more public workshops.

The other thing is Chapter 1200 changes that were approved in January and April are going to public hearing on November 8th. Those were revisions to the ADD/ADHD criteria, long-acting narcotic criteria, Suboxone revisions, Hep C agents. All these changes should go into effect on November 9th. That is all I have.

Shannon Sprout: This is Shannon Sprout, I'm the Chief over Policy Development and Program Management. In addition to what Mary provided, at the Summit there was a lot of information about the CDC guidelines, the statistics that are being taken nationally that I think are aligned really well when I went to the National Association for State Health Policy. There was again, the first full day was on the opioid crisis and what the states are doing. What we are really looking at is how we are going to move our policy to align with the movement that is occurring to make sure we are getting ahead of this crisis. So what you will see at the workshops that we will be holding is an effort to continue to have an open dialog with our providers and taking steps to make sure we are in line with those CDC Guidelines.

Paul Oesterman, Chairman: I think one of the big take-backs that I got from the Governor's Summit was we are all on the same page, we are all trying to accomplish the same thing. It doesn't do any good to point fingers, blaming

physicians or pharmacists or patients, we all need to work together and everybody appreciates the fact that it is a common goal. I am looking forward to tonight's discussion because I think we are going to be able to put some of our first steps into place. There are going to be some bumps in the road, but we have to do something. If we can impact one life, then we have done something very worthwhile.

James Marx: I would like to say that I came away with the same warm fuzzy feeling, but I didn't. There seems to be a lot of reliance with the CDC guidelines. There seems to be a lot of ignorance on this whole subject. It isn't because people know too much, it is because they know too much of the wrong thing. I think we have a big challenge amongst our prescribers. I was at a drug take-back this weekend and we had patients bring in medications left from a surgical procedure, but they get 100 Lortab and they only took two of them. This is far too common. And this is one thing they want to address, but mandating the seven-day rule is wrong, and I think we will get to that. There is a lot of misinformation. We have a big challenge to train our prescribers how to appropriately prescribe. We have to train the public as to behaviors and the proper mindset so there are some big challenges. It is not going to come from any set arbitrary guidelines.

c. Presentation of Annual Drug Utilization Review Report

Paul Oesterman, Chairman: We are going to have the Annual Drug Utilization Review Report. I will ask for public comment first. This is a report that is submitted annually and is due by September 30th. This report has already been submitted. Carl, do you want to run down the report?

Carl Jeffery: This is similar to the past years, a standard report. CMS seems to add a few new features every year. Mostly it is the same information. The first couple pages are demographic information. I will highlight a few things I think you may be interested in. Question 26, this was a new table, this is the top PA requests by PA drug name. I think it is a little more useful. I will let the Board continue to review it and let me know if you have questions. After question 42, the next page starts the summary of the Drug Use Review Board activities. That is what we provide to CMS that tells them what we have been doing all year. This is also the Federal Fiscal Year 2015, so it is the time when we did the special psychotropic meeting with the prescribers to create some new criteria. And the Executive Summary on the second to last page, not a whole lot to call out. Pretty standard information of what we go over every meeting. If there is something we should have submitted differently or something else, let me know. CMS will compile all these and make it available.

Paul Oesterman, Chairman: It looks like a very standard report. I didn't see anything out of the ordinary. We will need a motion to approve the report as submitted.

James Marx: On question 80, it asks about access to boarder states' PMP, we do have access to all the border states except California.

Mary Griffith: I don't think we do, do we?

James Marx: We have Arizona, we have Utah, but not California. The No is a qualification, they are in the PMP.

Jeff Zollinger: I am registered on the California PMP, but if you log into the Nevada PMP, you will get some of the other neighboring states except for California. So you have to register separately for California for their PMP. I have heard they are working on it, that California was going to work with our program. That would be nice to have that. The California PMP is very glitchy. It will go for a few months without problems, and then I can't get in when I have a patient there. It is not a good system. On 122, some of the MCOs in Nevada have some really stringent criteria for getting things approved, and it is very difficult. I think this is a good idea for MCOs to report their process, I think that is what they are asking there. Would that be available to us as the Board? What is the plan for that?

Mary Griffith: CMS is mandating that the MCOs have a DUR program. I'm not sure when the final rule will be in effect, but this is part of the requirement. They will have to have a DUR Board that is open to the public.

Jeff Zollinger: I have noticed that the MCOs will pick a third party reviewer, and they will switch back and forth. The one Amerigroup was using about a year ago was fairly straightforward, and then they switched and it became very difficult to get things approved. To me I get the feeling they chose the administrator based on who is going to deny the most. That is a big frustration.

Mary Griffith: Yeah, we hear a lot of complaints, we hear the fee for service is a lot easier to deal with.

Shannon Sprout: If there are concerns or issues, you should bring those to us so we can work with the MCOs.

Mary Griffith: If you can send some examples, we can look into that.

Jeff Zollinger: I can probably give you a list. It isn't just medications, it is also imaging, physical therapy and other therapies. I heard this complaint at a meeting a few years ago from another physician.

Mary Griffith: If you let me or Carl know, we can look into those issues, not just the pharmacy piece. One thing that is part of the CMS final rule with the DUR requirements, we are required to have a response to prior authorizations within 24 hours and we are required to have a 24 hour pharmacy call center, and the MCOs don't have the same requirement, but they will when the final rule goes into effect. I will give you my card and you can email me. At this point, that is all we can do.

Jeff Zollinger: When does that final rule go into effect?

Mary Griffith: I think it is 2017 some time. I don't have the specific date. But it is a CMS rule.

James Marx: I have an issue with the lock-in program. We have only had a few patients on lock in. But recently a patient had a prescription for methadone in addition to a short acting. The pharmacy where she is locked in refused to order it for the patient. I advised the patient to go to the emergency room when she went into withdrawal.

Mary Griffith: The lock-in program is not perfect, but the recipient can go to a different pharmacy.

James Marx: The problem is if a patient has been locked-in, when they go to another pharmacy to change, there is a stigma on the patient and they are reluctant to help. Pharmacists are already reluctant to fill prescriptions for these patients. It doesn't take much to make a pharmacy refuse these patients. It is frustrating and I think the lock-in program needs some criteria for the retail pharmacies. This is a bad situation when a patient goes into withdrawal because a pharmacist refuses to fill a prescription.

Shannon Sprout: We can put this on a future workshop.

Paul Oesterman, Chairman: Let's also put Lock-in on the next agenda to look at the criteria. In the mean-time, we need to approve the annual DUR report.

James Marx: I move to approve as submitted.

Chris Shea: Second.

Voting: Ayes across the board, the motion carries.

4. Clinical Presentations

- a. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for medications used to treat Hepatitis C.

Paul Oesterman, Chairman: We have a couple clinical presentations, we are going to cover item 4 B first, the discussion and possible adoption of prior authorization criteria for medications used to treat Hepatitis C.

Do we have any public comment? Hearing none, we will go ahead with the presentation of the clinical information.

Carl Jeffery: This one is pretty easy. There is a new medication, Epclusa, a new pan-genotype medication. The AASLD guidelines are easy because there are no required combinations with ribavirin or previous treatments. On the proposed criteria in your binder, the recommendations right out of AASLD is added. It follows the genotype and if they have been treated with something else. It is a 12 week therapy.

Paul Oesterman, Chairman: The utilization data, the total number of hepatitis treatments has been fairly constant. A little drop in the Harvoni product as new products have been introduced.

Carl Jeffery: It has stabilized. I think when we first looked at these, there was some panic that these would go through the roof. We are not doing anything to regulate the number of prescriptions approved. I think the prescriber community is self-regulating and only treating those who really need treatment.

Paul Oesterman, Chairman: We need a motion to approve the updated prior authorization criteria for the medications used to treat hepatitis C.

Jeff Zollinger: I move to adopt the criteria.

Chris Shea: Second.

Voting: Ayes across the board, the motion carries.

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

Paul Oesterman, Chairman: Now we will go back to 4 A, the discussion and possible adoption of prior authorization criteria and/or quantity/prescription limits for the medication class opioids and opioids agonists used for the treatment of pain. Do we have anyone in the audience that wishes to address the Board? No comment.

As we started with this meeting, there have been a series of forums to address the concern with prescription opioid abuse and potential misuse. One of our mandates is to assist in the prevention of overdoses and fatalities that occur way too often, not just in Nevada, but the entire country. We started off with a basic guideline from the CDC for possible criteria that could be used. This is a guideline, a starting point, not an endpoint. We want to see some of the proposed suggestions to see what we can do to curtail addiction. Many patients start with acute pain and like the effects they get from the opioid and then become chronic users. That is what we want to look at, it will be a long process and we will not cure it overnight. I am involved with the DEA takeback programs in Northern Nevada. Someone is given a prescription for 120 oxycodone, they take two and then it sits in their medicine cabinet. Then a friend or family takes the remaining pills and it ends up on the street. What do we have for a starting point?

Carl Jeffery: We have some good utilization numbers to start. The first chart is the top 20 opioid utilizers. The top one is a methadone patient, 15,000 units, a lot of methadone. I think these are 10mg, since they took the 40s away from the retail pharmacies.

Paul Oesterman, Chairman: I calculate that as 41 tablets per day.

Carl Jeffery: I'm not so concerned with the top one, but a little down the list, you see the members with all the combinations. The one at the bottom of the first page is concerning. You have quite a few of these medications adding up. This brings to light what we need to focus on, the multiple medications and the large

quantities. The methadone patients will be a little unique if using them for drug withdrawal. I hope nobody is using for pain treatment.

James Marx: I use methadone in my patients, it is an excellent medication for pain, and have used it for over 20 years. They need to get it through a treatment center if using for withdrawal.

Carl Jeffery: The next report is the top opioids trending graph. The hydrocodone and acetaminophen combination is by far the top, followed by the oxycodone and acetaminophen. Then it works its way down. Embeda is now preferred as an abuse deterrent.

James Marx: Are these individual claims?

Carl Jeffery: Yes.

James Marx: So this is an aggregate?

Paul Oesterman, Chairman: Those are individual patients.

James Marx: Are those total milligrams?

Carl Jeffery: Those are number of tablets.

James Marx: 15,000 tablets? That's not possible.

Carl Jeffery: Yes.

James Marx: I want to see that claim.

Carl Jeffery: It is over a year time.

James Marx: Oh, ok, I can see that maybe in a year, that's still a lot. That is over a 1000 month. I would still want to see that.

Carl Jeffery: We can try to get some consolidated case studies so we can look at patients like this. We need to be careful of PHI.

[Inaudible side conversation]

Paul Oesterman, Chairman: The concern is the patient getting 15,000 tablets per month, then the next is patients getting four or more opiates per year. Do they get them at the same time or transition from one to another? For me, the third patient down, they got a 120 of one item and then 240 of another, that is probably a couple fills. But a little further down, they have seven different opiates, there are some smaller quantities and some with really big quantities.

Beth Slamowitz: When you look at some of these patients with multiple products, are they seeing multiple types of prescribers, like ERs to primary care to a pain specialist?

James Marx: The other issue is the strength of the tablet, there is no way to know the total dose.

Jeff Zollinger: I think that would be interesting to see if these are getting paid together.

Paul Oesterman, Chairman: I would like to see on these 20 patients to look at the calendar for what they are getting and when.

Shannon Sprout: As we are pulling the data, we are also doing the work on the back end to identify trends and issues that we need to look at. We are doing that now, and we will present that to you.

James Marx: I think it would also be helpful to have diagnosis codes and hospitalizations or ER utilization.

Beth Slamowitz: We just did a presentation for ER visits and how their medications tied into the visits. Some of the data is very hard to drill down, especially when it comes to diagnosis. You are seeing why they came to the ER, not why they are getting a pain medication. You can't tell truly what the diagnosis is, I just want to give that disclaimer before we run the data. If that is what you are looking for, that might be data that is hard to come by. But we can see if these 20 recipients went to the ER or were hospitalized.

Paul Oesterman, Chairman: It might also be valuable to add in concurrent benzodiazepine use. This is an open forum, if anybody in the audience has anything to share, please step forward.

Coleen Lawrence: My name is Coleen Lawrence with Moxie Health Policy. I would offer a suggestion on that data, I was not sure if it was point of sale or physician administered data. The delivery model would be a clarification that you might want to look at. If it was being administered in the emergency room or a doctor's office vs. a retail setting. And then the type of specialty of the provider that is providing the medication. That might help you narrow the buckets.

Chris Shea: That is helpful, because we have had patients discharged on a list of medications to rehab. When they are admitted to the hospital, and they are discharged on the same medications, then the admitting prescriber to the rehab facility needs to figure out where these medications are coming from. It does help to know where these prescriptions are coming from so we know what to look at.

Coleen Lawrence: That will help on the education side.

Carl Jeffery: These are all point of sale claims, there are not any physician administered drug claims.

Coleen Lawrence: Then you have another whole set of medications being given in a clinic setting that would need to be addressed.

Kerry Bonilla: I am Kerry Bonilla with Astra-Zeneca. The data set is a challenge when I talk to providers in every group. We have a lot of data, if there could be some communication back to the ERs. Some of these patients may only see ERs. The primary diagnosis is important to see on these patients. Maybe part of the whole dialog, the ER physicians could make sure they are coding properly.

Jeff Zollinger: I would add, looking at these patients here, I hope they are not being prescribed by the ER physician. I don't think they should be prescribing any long-acting agents.

Beth Slamowitz: I can tell you from my experience, at UMC outpatient, the outpatient pharmacy at the clinic, the majority of the prescriptions came from the ER. The majority of those were for pain medications until a pain protocol was put in place. We did get prescriptions for long-acting agents. That is because the patient comes in for a refill of their routine pain medications.

Jeff Zollinger: Then you are just reinforcing bad behavior at that point.

Beth Slamowitz: I agree, that is why we are here now. Protocols to limit days supply have helped.

James Marx: We used to have patients take their medications with them to the hospital, but they don't get them back on discharge. It is a real problem.

Beth Slamowitz: We would keep them in the pharmacy, locked in a cabinet until discharge. Then the nurse or patient needs to come get them when they are discharged. Meds were destroyed if they didn't get them.

James Marx: I think there should be a better system to get the medications back.

Beth Slamowitz: That is good in theory, but with a hospital the size of UMC, that can't happen.

Paul Oesterman, Chairman: In my hospital it is the case manager that reminds the patient to get the medications. I had two bags of meds to destroy because the patient passed away. So it doesn't seem to be a problem.

James Marx: We tell our patients not to take their medications to the hospital. Another issue is if the patient gets too much opioid, but that is not common with my patients. I think we need to do a better job.

Beth Slamowitz: I think our concern here is that we need to look at a starting point, and looking at the outpatient now. The criteria we have is similar to what some of the other states are looking at.

James Marx: The inpatient side does roll down to the outpatient.

Beth Slamowitz: That is something we can take away to address at a later time.

Paul Oesterman, Chairman: Looking at the top 20 opiates by claim count. The combination hydrocodone is number one, looking at the numbers, there are a lot of people that are in pain, but the average claim ran between 63 to 109 tablets per prescription. I understand patients with chronic pain, but to get an average that high, there are a lot of patients probably getting more than they need.

James Marx: You have to look at it from the other side. The quantity limits one or two pills per day, this leads to higher strengths on the street. I like my patients to take more tablets that are lower doses. I think we need to rethink the quantity limits. You have to think of the total dose per day rather than number of pills.

Paul Oesterman, Chairman: I understand that, but what we are doing now is not working, and we need a starting point for something to help. Other states have tried these, but we need to do something.

James Marx: Do you want a bunch of 30mg morphine tablets or 100mg tabs on the street?

Paul Oesterman, Chairman: I don't want either of them on the street.

Shannon Sprout: When we look at the national research, states are moving to a supply limit, a 3 or 7 day supply. This is the first proposal and round for you to review. But that is where the national trend it moving and they have had some success.

James Marx: Are these based on CDC guidelines?

Beth Slamowitz: The CDC recommends no more than a 3 day supply for an acute episode. If more is needed then they should require PA.

James Marx: Would surgery be a reason?

Beth Slamowitz: Yes, and that is an exception on the criteria. The states have gone to some middle ground so some are doing a 7 day supply. This helps limit the number of pills patients can get if they are doctor shopping.

James Marx: The PMP should stop the doctor shopping.

Beth Slamowitz: Yes, and this was addressed at the summit, but there is no penalty for not looking at the PMP, it is encouraged, but not mandated.

Jeff Zollinger: I think it does say there is a disciplinary action, maybe even something criminal on the original. It scared a lot of doctors. It said the doctors could be committing a crime.

Beth Slamowitz: It leaves it to the Boards to decide the disciplinary action.

Paul Oesterman, Chairman: I'm looking at the proposed criteria, I think I would like to add one more potential exception, and that is if the patient has been seen or is prescribed in consultation with a pain specialist.

James Marx: That is pretty impossible, there are not enough pain specialists.

Paul Oesterman, Chairman: That would be an exception.

James Marx: I know this would help me, but in a bigger picture, most pain management is done by primary care doctors.

Mary Griffith: I don't think that is the case here. In a recent report, we looked at all the narcotics, the vast majority are coming from one pain specialist office, and they were all in the top five. The data that I have seen did not back that up. It was not the primary care doctors.

Michael Owens: From a personal practice, it takes 3-4 months to get someone into a pain specialist. I know that is the same way for all the prescribers in our clinic. It is a distraction in our practice. It does seem there is a shortage of pain specialists.

Paul Oesterman, Chairman: I want to go back to the proposed criteria, and especially the people in the audience, we know this is just a starting point, if the initial prescription is for 7 days or less, it would not require a prior authorization.

Patients that have had a prescription within the last 45 days would be exempt, so we are trying to start from the beginning with new patients. I think it is a small number of patients we are looking at initially. It will prevent them from getting into trouble down the road.

James Marx: Will that impact the call center?

Beth Slamowitz: As long as the prescription is for 7 days or less, then they do not need a PA.

James Marx: But what happens after 7 days?

Beth Slamowitz: They get another 7 days.

Carl Jeffery: They can get that up to 13 times.

James Marx: Who is going to paying for all those office visits? The patient is going to have to be coming back.

Carl Jeffery: The intent is to catch those for acute pain. They get 7 days' worth and then they are done. We don't want dentists writing for 30 days of Percocet.

Shannon Sprout: The goal is for individuals with an acute issue. A 7-day supply is sufficient. We want to get away from the larger quantities that may start a pattern with someone. If you meet with a patient that needs more than 7 days, then you would initiate a PA. But we want to stop the 30-days supply when a 7 day supply would be just fine.

James Marx: I guess my issue is that we should have prescribers that are educated, if someone tears their ACL, they will have pain for more than 7 days, and now they need a prior authorization. I think there is going to be a much larger unintended consequences of a lot more work on the prescribers.

Shannon Sprout: That is why we are trying to step this up slowly so that we can look at the outcomes. If we do everything at once, we can't tell what is working or not. We have had a workshop on this.

Jeff Zollinger: I think this is a good idea and I would support this, as long as you are prepared for a greater administrative burden. I think if we are prepared for that, then I support this.

Carl Jeffery: If we can be the scapegoat, prescribers can blame Medicaid and relieve the physicians from that pressure, I think that would help.

Jeff Zollinger: I think it would. I have heard other physicians tell patients that based on what the insurance will cover. Many insurance companies only covers a small amount, and the patients are generally ok with that. So I think it might help. It lessens the conflict with the patients.

Michael Owens: Our clinic has adopted the CDC guidelines, we are not taking any new opioid patients. We have a monthly morphine equivalent max. That is the only way I could prescribe. I have a hard time telling patients no, but this gives me a good background to deny some patients.

James Marx: So you are not taking any new patients?

Michael Owens: Right, I am not a pain specialist, I'm sure they may have pain, but to put me in the position to write for medication I am not comfortable with, that is not what I signed up for. I don't have the control over the situation that I would like.

James Marx: 40% of encounters in the primary care environment is for pain, so it seems you would be excluding many patients that could be helped. I can see if they are on high doses, those patients probably need to be in pain management. I did have an opioid naïve patient, I wanted 2.5 mg Percocet, and we could not find it or the pharmacy could not get it. This is a problem that we can't get the lower doses.

Chris Shea: I think it boils down to an economic issue, a supply and demand. No one uses the 2.5 mg. You could have used a half of a 5mg tab.

James Marx: That is what we ended up doing, but for the elderly, it isn't a good solution. That is where we need to start working.

Jeff Zollinger: I think what we are trying to do is to prevent these patients from getting hypersensitive on these high doses. That way we don't have the patients going back to primary care getting their doses escalated. I see this frequently, a patient gets injured, they can't get in to an orthopedic on time, doses get escalated, and by the time they are in the pain clinic, they are on an extremely high dose. Hopefully this new proposal will mitigate some of these issues.

Paul Oesterman, Chairman: Right, this is a starting point, there will be some amendments and some changes in the future. Do we have a motion to approve?

Michael Owens: Is this for 7 days per month?

Carl Jeffery: It could be consecutive 7-day fills, they could go through their 13 fills right away.

James Marx: If you are going to limit to 7 days, then you should limit the dosage. Otherwise, it will create a pull for the 2.5mg tablets. If you will give them 7 days of 10mg Percocet, then it is missing the purpose.

Carl Jeffery: I think that is a great idea, throw out some numbers, in a 7 day period, how many morphine equivalents should be allowed for an acute treatment.

James Marx: I think you need to look at a daily basis. There should be some establishment of an opioid naïve patient. If you want to create an addict, give them something they like.

Carl Jeffery: We can put a quantity limit, it would be done at the product level per seven days. But what we have coming in early 2017 some software that will calculate the morphine equivalent dose, but for now it would be a large manual effort.

Jeff Zollinger: I think if you want a number, the CDC has a dose limit.

James Marx: The CDC guidelines are all level 2 and 3 evidence, there really wasn't any good evidence. It is poor evidence they are based on.

Jeff Zollinger: But it is the only evidence we have right now. They looked at one study of patients having a poor outcome when they exceed certain doses. When we are looking for a number, let's say 100mg morphine equivalent per day.

Beth Slamowitz: We are setting a max, the prescriber can still prescribe anything under that limit. If we start with baby steps.

James Marx: But if we start with something too high, then we are not going to be doing any good.

Shannon Sprout: I would ask then, would it be appropriate that we may need some additional information to come back with those limits at the next meeting?

James Marx: I think we can get something out of this.

Paul Oesterman, Chairman: What if we add no more than 100mg morphine equivalence per day.

Jeff Zollinger: I would say 120mg per day.

James Marx: If we are going to make this a usable guideline, I think 20mg morphine per day is good for an opioid naïve patient.

Darrell Faircloth: Will the experienced opioid user be getting a prior authorization?

Jeff Zollinger: What about a patient not opioid naïve who hasn't filled anything in 45 days, and then has surgery?

Beth Slamowitz: The exception criteria would allow that since they are having surgery. We can add 120mg within 24 hour period. How do we figure out who is opioid naïve?

Carl Jeffery: It is always easier to come down. From the claims side, we can't always know who is opioid naïve vs opioid experienced. What we are talking about here is putting in the system as limits, anything that exceeds the max we establish will require a PA.

Paul Oesterman, Chairman: This is just a starting point, we can create some framework and go from there. We have some public comment.

Elyse Monroy: I am Elyse Monroy and I am the Health and Human Service Policy Analyst in the Governor's office and I have been working on these issues. I want to throw something out, something that really resonated with me and a few others, during the Governor's planning meeting, one of the individuals that gave his personal story that they wish someone would have just told me of the risks of opioids. He had a fall that started opioids for pain and spiralled to heroin. Other states encourage patient consultation.

Paul Oesterman, Chairman: Patient consultation is required by a pharmacist.

Elyse Monroy: But not by a prescriber. If I was told how an opioid works and the risks, I think I would ask for something else, I don't think I am the only one. If there is a place for consultation, I think that would help.

Paul Oesterman, Chairman: One thing that resonates and keeps coming up is education.

?: I cover Oregon, I cover all the managed Medicaid, and they are starting to ask the patients if they are opioid naïve. My dad had a knee replacement last week, he had a 120 Percocet, he took 8, now on ibuprofen and now we have all these Percocet in his medicine cabinet. Patients have been trained with antibiotics to finish therapy, that is the biggest drug that patients take. Now you prescribe something for PRN use, they don't always know how to take it.

Carl Jeffery: Maybe we add under number 2, patient has been educated about the risks and the benefits of an opioid.

James Marx: Where is that supposed to take place?

Beth Slamowitz: It wouldn't be anything more than an attestation. I don't know that that does anything.

Chris Shea: If you look at the discharge summaries from the hospitals, it says the PMP was checked, the patient was educated and we told them to stop smoking.

James Marx: There are 10 times as many die of smoking related illness than opioids.

Beth Slamowitz: We need to look at the criteria we have here.

James Marx: Why don't we create a patient education sheet that needs to be given with every opioid prescription?

Shannon Sprout: We have to look at what we can do within Medicaid and what the DUR Board can do. The education for patients is something we can take back. For the purpose of this, we will take the education material and go to public and behavior health and come with a collaborative effort across the Division. You have the option to do that in your clinic now.

James Marx: We have the opportunity to educate the patient at the pharmacy. If they want the prescription, then they have to listen to the pharmacist.

Chris Shea: That needs to come from the Legislature. The patient has the ability to deny counseling. What is being proposed is beyond the ability of the DUR Board.

Carl Jeffery: Are med guides required for opioids?

Chris Shea: No, but even with those, we have to hand them to the patient, but they still have the right to refuse counseling. We have to document it.

Paul Oesterman, Chairman: You can't force a patient to listen to your counseling. We have the proposed criteria, we added a couple points, Carl do you have those points?

Carl Jeffery: Yes, we added the morphine equivalent doses, not to exceed 120mg per day.

Paul Oesterman, Chairman: And we are going to add education.

James Marx: I thought we were going to use a smaller dose.

Carl Jeffery: This is for the seven day limit, looking at 120mg limit, anything exceeding that. If you set it at 20, you're going to trigger a lot of PAs.

Chris Shea: Isn't that something that if we put 120 in now, then we could review that in the future and lower the ceiling if appropriate.

Paul Oesterman, Chairman: Do we want to lower it to 100?

James Marx: I want to lower it to 40mg.

Michael Owens: Don't they get 30 days after discharge for requiring prior authorization?

Carl Jeffery: That only applies to psychotropics.

James Marx: For non-post-operative pain, 100mg is way too much.

Shannon Sprout: Would you prefer the data at the next Board meeting and create the limit then? Then just make the decision on this proposed criteria today, and review again at the next Board meeting.

James Marx: Let's set the limit low and see how many object to it. Let's set it at 40, and then we are guiding behavior. If we set it at 100 or 110, then people will think that is appropriate for non-surgical pain.

Jeff Zollinger: What would be a typical prescription for an acute injury?

Michael Owens: Let's say someone comes with a sprained ankle, can barely walk, we wrap it and give them crutches. The most I am willing to do now is for a short prescription is four or six 10mg tabs per day.

James Marx: I would give them a shot of Toradol and 800mg of ibuprofen.

Michael Owens: But he was asking about opioids, the usual dose would be about four to six tablets per day.

Jeff Zollinger: That is my suspicion, it will create a huge administrative burden for triggering prior authorizations.

James Marx: We need step therapy, the question should be has the patient been on a non-steroidal at the max dose. If we are not going to do that, then we are perpetuating the problem.

Beth Slamowitz: That is already in there. Should we read the criteria?

James Marx: They may consider it, but they don't do it.

Paul Oesterman, Chairman: I think we are trying to come up with our morphine equivalent max. I would propose we consider 60 as splitting the difference and come back next time with data with the doses that are prescribed.

James Marx: I'll settle for 50mg.

Paul Oesterman, Chairman: Ok, 50mg morphine equivalents? Any other comment?

Jeff Zollinger: I think the lower the better, but there are a lot of people that prescribe more than that. You have already gone lower than what Dr. Owens says he would prescribe. The other thing is maybe for another day is long-acting agents.

Paul Oesterman, Chairman: So are we at 55 or 60?

Chris Shea: 60 would be easier to prescribe.

Paul Oesterman, Chairman: We have the criteria with the education piece and no more than 60 mg morphine equivalents per day. There is always an opportunity for a prior authorization to exceed. We need a motion.

Jeff Zollinger: I motion to approve as presented.

Michael Owens: Second.

Voting: Ayes across the board, the motion carries.

James Marx: If we are not getting a lot of objection to the 60mg, I think we should ratchet it down.

Paul Oesterman, Chairman: I agree, for the next meeting, can we have the data be brought back. When will this be implemented?

Mary Griffith: It has to go to public hearing, so probably about 6 months.

Paul Oesterman, Chairman: So not for the next meeting, but it would be interesting to see what medications that come out of the emergency room.

Carl Jeffery: I will try to tease it out, but it would be interesting to see the details of first-time fills.

Chris Shea: And then can you break it down by prescriber type?

Carl Jeffery: We can try, but sometimes, the specialties are not accurate in our system.

5. Public Comment on any DUR Board Requested Report

Paul Oesterman, Chairman: We will move along on the agenda, next is the Board Requested Reports. Do we have any public comment?

6. DUR Board Requested Reports

PO: The first one is utilization of agents used for the treatment of Opioid Induced Constipation.

Carl Jeffery: This is a follow up request. The criteria has not been implemented yet, so we won't see any shift in utilization yet. There is a break out of the different products.

Paul Oesterman, Chairman: I think it is interesting to see the increase in Movantic and maybe is related to the tv advertising. Are you aware of any head-to-head studies with Amitiza and Movantic?

Carl Jeffery: I'm not aware of any.

Paul Oesterman, Chairman: When will this criteria be implemented?

Carl Jeffery: November 9, 2016.

Paul Oesterman, Chairman: Maybe we can bring it back then.

James Marx: There is an oral product coming out and it should be available soon.

Paul Oesterman, Chairman: The next on the agenda is the non-opioid pain medication utilization. One of the things we were looking for is if there were any increase in utilization when hydrocodone went CII.

Carl Jeffery: I don't see an increase.

Paul Oesterman, Chairman: I have a question, Humira and Enbrel?

Carl Jeffery: I saw that and left them in there, they are technically non-opioids for pain like rheumatoid arthritis. And I thought it was interesting their quantities still fall in the top 20.

Paul Oesterman, Chairman: Pretty consistent.

Carl Jeffery: We will have to monitor after the opioid change.

Paul Oesterman, Chairman: After implementation, we will have to bring this back. The next report is the one we struggle with is the correlation of emergency room visits for asthma and COPD and current treatments.

Carl Jeffery: We took all the members with a diagnosis of asthma or COPD in an ER visit and then pulled what medications they are on. We have a chart that breaks down all the people that had a diagnosis on an ER visits, almost 5,000 people, when we get to the number of people on a steroid, we are about 1,000 patients. That means we have about 4,000 members who were admitted to the ER for asthma or COPD and not on a steroid inhaler. I think there is a big opportunity for education. We could look at a retro-DUR. We could look for recent ER admissions, check their profile and then send a letter to the prescriber alerting them their patient is not on adequate therapy.

Paul Oesterman, Chairman: The next report is the diagnosis of esophageal cancer and proton pump inhibitor utilization.

Carl Jeffery: This didn't show anything like I thought it might. The first chart is the number of members with a cancer diagnosis, about 92.

James Marx: Is there any overlap that have more than one diagnosis?

Carl Jeffery: Could be, I didn't compare. But then you look at their medications, and not many are on a PPI. There are only 8 patients that are on some kind of GI medication.

Chris Shea: Why were we looking at that?

Paul Oesterman, Chairman: I think we were looking for a cause and effect.

Carl Jeffery: I think you would need to do a lot more data mining to make this more useful. We would need to take these 92 patients and really dig into their medications for the last 10 years and other risk factors. We wouldn't have information on that.

Paul Oesterman, Chairman: The next chart is all the GI related medication utilization, I found this interesting. We have a number of proton pump inhibitors and H2 receptor antagonists. Ranitidine shows up twice, once at the top and then about half-way down.

Carl Jeffery: That is the over the counter. This is every fee for service patient that has been on any kind of GI related medication. About a year ago we put a limit so they can't be on a PPI and H2 concurrently. I thought we were going to get a lot of pushback, but we really don't hear too many complaints.

Paul Oesterman, Chairman: Maybe more of a question for the P&T, is there any advantage for preferred products in this category.

Carl Jeffery: Yes, they are an included class and Nexium and pantoprazole are the preferred medications.

Paul Oesterman, Chairman: There is a lot of famotidine and ranitidine.

Carl Jeffery: What we can do on the P&T side is force the use of the generic.

Paul Oesterman, Chairman: If you look at the sum of the paid amount, the Nexium, is there a contract, it seems like that is a lot, but I'm not sure that is the final cost.

Carl Jeffery: That isn't the true cost.

Paul Oesterman, Chairman: Is it possible to do a follow up for those patients on PPI that have been on it for an extended period of time to see if they have had an endoscopy or GI consult.

Carl Jeffery: For those types of requests we have to work with the medical claims vendor. We can try it.

Paul Oesterman, Chairman: Cough suppressants with dextromethorphan or guaifenesin.

Carl Jeffery: The first graph shows all the cough suppressants total, I thought it was interesting. I don't ever really think of it, but benzonate is the largest use. Promethazine has the quantity limits now.

James Marx: How much did the utilization change with that quantity limit.

Carl Jeffery: We looked at that at one of the other meetings, and there was a pretty good reduction. The use looks to be seasonal, the fall and winter shows an increase. Liquid combinations are next, most of these are pretty reasonable.

Paul Oesterman, Chairman: When I tried to review the top 20 cough suppressant with the liquids, the guaifenesin with codeine has about four different entries, it doesn't look like they are reflected in the liquid combination, only the Iophen C is there. I think for the most part, most practitioners, the guaifenesin with codeine is the go-to cough syrup.

Carl Jeffery: I think it is because of the way they are listed in our system, the combinations with codeine fall in the codeine class.

Paul Oesterman, Chairman: Can you bring this back next time with the codeine?

Carl Jeffery: Sure, the request for this report was combinations of dextromethorphan and guaifenesin. We can look at that next time.

Paul Oesterman, Chairman: I know why we looked at the promethazine before, we might want to consider quantity limits on the codeine products for next time.

7. Public Comment on any Standard DUR Report

Paul Oesterman, Chairman: Now we have the DUR Standard Reports. Any public comments?

8. Standard DUR Reports

Carl Jeffery: These are the regular charts with the Q3 added. Factor products and antipsychotics are always fighting for number one for amount paid. Hydrocodone always takes number one in the count of claims. We called out the hepatitis treatments, but it is holding steady or maybe even dropping a little. Same with the top 50 drugs. Everything is holding steady and not out of the ordinary.

Paul Oesterman, Chairman: I am seeing a good pattern for the average day supply, generally less than 30 day supply, I'm assuming patients are being started on a shorter day supply.

Carl Jeffery: You're looking at the Lisinopril and atorvastatin. I wouldn't guess it is a starting dose, but rather the nursing home pharmacies doing a short fill. They're not supposed to be doing it that way.

James Marx: On the second quarter, there were 129 claims for naloxone for \$313,000, is this over \$2000 per claim?

Paul Oesterman, Chairman: Have there been any issues with Epipens?

Carl Jeffery: As far as supply? Not that I am aware of. I heard Auvi-Q is coming back and there is another manufacture that is trying to come out too. I'm sure there will be some class-action activity coming down the road.

Paul Oesterman, Chairman: Our retro-DUR.

Carl Jeffery: I don't have anything to report this time, but I'm always looking for ideas. I think we have one with the asthma and we will get that one rolling. The Pro-DUR is more of the same.

9. Closing Discussion

Paul Oesterman, Chairman: Closing discussion. Any public comment? Date and location?

Carl Jeffery: January 26, 2017 probably right back here.

Paul Oesterman, Chairman: Meeting adjourned at 7:40PM.