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STATE OF NEVADA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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*Governor*

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Acting Administrator

**DRUG USE REVIEW BOARD**

**Meeting Minutes**

**Date of Meeting: Thursday, August 24, 2017 at 5:15 PM**

**Name of Organization: The State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP), Drug Use Review Board (DUR).**

**Place of Meeting: Holiday Inn Reno-Sparks**

 **55 East Nugget Ave**

**Sparks, NV 89431**

**Phone: (775) 358-6900**

**Event Number: 311 118 149**

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**A password should not be necessary, but if asked use: dvMYb222**

**Attendees**

**Board Members (Present) Board Members (Absent)**

James Marx, MD Paul Oesterman, Pharm.D.

Chris Shea, Pharm.D.

David England, Pharm.D.

Michael Owens, MD

Jennifer Wheeler, Pharm.D.

Marta Bunuel, MD

**Reno**

**DHCFP:**

Shannon Sprout, Deputy Administrator

Darrell Faircloth, Deputy Attorney General

Holly Long, Social Services Program Sp

Duane Young, Chief, DHCFP

**HPES:**

Beth Slamowitz, Pharm.D.

**OptumRx:**

Carl Jeffery, Pharm.D.

**Public:**

Tom Beranell, Silver Summit

Paul Benham, Avexis

Lisa Wilson, Biogen

Kaysen Bacit, Biogen

Cheryl Donahue, Sarepta

Lisa Borland, Sarepta

Coleen Lawrence, Moxy Health

Keri Smith, ViiV

Lovel Robinson, Abbvie

Nindhana Paranthaman, BMS

Gary Okano, BMS

Jane Stephen, Allergan

Slater Sparks, Insys

Ann Nelson, Vertex

**Teleconference**

Laura Hill, Abbvie

Ryan Bitton, UHC

Chris Anstead

Elaine DeFelice, UCB

Jonathan McKinnon, MD

1. **Call to Order and Roll Call**

Chairman Dave England, Pharm.D., called the meeting to order at 5:30 PM and asked for a roll call. A quorum was established. Ground rules for the public speaking were established.

1. **Public Comment on Any Matter on the Agenda**

Dr. England called for public comment.

No comments.

1. **Administrative**
	1. **For Possible Action:** Review and Approve Meeting Minutes from April 27, 2017.

There was a motion to accept the minutes as submitted and a motion seconding the approval. The minutes from April 27, 2017 were approved.

* 1. **For Possible Action:** Review and Approve Meeting Minutes from July 13, 2017.

There was a motion to accept the minutes as submitted and a motion seconding the approval. The minutes from July 13, 2017 were approved.

* 1. Status Update by DHCFP

Mr. Duane Young, Chief of Behavioral Health and Pharmacy Services for the Division of Health Care Financing and Policy (DHCFP), provided an update of activities for the Division. Mr. Young spoke about CCHB going live on July 1 of this year in Reno, Las Vegas, Fallon and Elko. Mental health parody bill is under way, requires mental health parody among managed care plans and fee for service. An analysis of Children’s Health Insurance in the MCO’s has been conducted. The MCO expansion was effective July 1, 2017; Aetna is no longer participating and will be out of the MCO program effective August 31, 2017, leaving three MCO’s. Dental benefits will begin August 25, 2017, but fee for service will continue handling the benefits until January 1, 2018. Mr. Young welcomed two new members to the board nominated by the MCO’s, Dr. Marta Bunuel and Dr. Jennifer Wheeler, a third will be appointed and now this DUR Board represents all Medicaid for the State of Nevada.

1. **Clinical Presentations**
	1. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for eteplirsen (Exondys 51®)

Dr. England reminded the Board this is being reviewed to update the reauthorization criteria.

Dr. England called for public comment.

Ms. Lisa Borland, Medical Affairs representative from Serepta Pharmaceuticals, offered availability for questions.

Dr. Carl Jeffery, OptumRx, offered proposed criteria for Exondys 51 that removed the criteria for the ambulatory requirement in the re-authorization criteria.

Dr. England asked if there is a requirement to establish a baseline.

Dr. Jeffery suggests it would be based on the opinion of the prescriber. If the member was not maintaining or improving, the call center would not reauthorize the request.

Dr. Chris Shea, Pharm.D., asked if the intention was to remove the ambulatory requirement from the criteria.

Dr. Jeffery answered the initial evaluation and the renewal criteria was not consistent. The goal is to make the renewal criteria match with the initial criteria.

Dr. Michael Owens, MD, asked if there is some standard language that could be used, like maintaining clinically significant status.

Dr. James Marx, MD, pointed out that ambulatory status does not have to mean the patient is ambulating. Suggesting nothing in the language needs to be updated.

Mr. Darryl Faircloth, DAG, stated as long as the call center that evaluates and reviews the prior authorizations is consistent with the Board’s intent, the language is fine, but clarification would be helpful.

Dr. Beth Slamowitz, Pharm.D., DXC, asked if there is anything listed in the package insert.

Ms. Borland replied there is no restriction based on the indication. The intent of the treatment is to slow the disease, not necessarily maintain the same baseline status.

Dr. Jeffery suggested language could be borrowed from the Spinraza criteria; the patient has experienced a benefit from therapy compared to untreated patients.

Dr. Owens suggested leaving the language as clinically significant status would leave the judgement to the prescriber.

Dr. Slamowitz asked if the call center will know how to evaluate a clinical benefit.

Dr. Jeffery responded that the call center would rely on the word of the prescriber.

A motion was made that line 1.1.2 in the proposed criteria be amended to read the patient is showing satisfactory benefit from the treatment. The motion was seconded and approved.

* 1. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for nusinersen (Spinraza®)

Dr. Jeffery reminded the Board for purpose for this topic is to clarify the renewal criteria for Spinraza.

Dr. England called for public comment.

No public comment.

A motion was made the criteria for Spinraza be accepted as presented. The motion was seconded and accepted.

Dr. Marx asked for more information about SMA.

Dr. Jeffery provided information on utilization trends and the usual dosage patterns.

Dr. Bunuel asked if the numbers were just for Nevada.

Dr. Jeffery responded that this information is just for the fee for service data, not MCO utilization data.

* 1. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for COX-2 Inhibitors.

Dr. Jeffery stated this item was brought to the board to remove the clinical criteria. The medication is non-preferred through the preferred drug list and the utilization is not high.

Dr. Marx asked what the exception criteria is to get the medication.

Dr. Jeffery responded that two preferred agents would be tried unless there is some compelling reason the prescriber needs to have the non-preferred medication for a specific indication.

Dr. England called for public comment.

No public comment.

The Board reviewed the utilization data and the current prior authorization criteria. The request made to the board was to remove the criteria to allow easier access for members.

A motion was made to remove the celecoxib, COX-2 clinical criteria. The motion was seconded and accepted.

* 1. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for Antiemetics – Delta-9-Tetrahydrocnnabinol (THC) Derivatives.

Dr. Jeffery provided a brief description of the new drug, Syndros, available in this class. A red-lined version of the criteria was presented to remove the brand names and instead make reference to the class or generic name.

Dr. England called for public comment.

No public comment.

A motion was made to accept the changes to the criteria as presented. The motion was seconded and accepted.

* 1. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for Targeted Immunomodulators.

Dr. Jeffery provided an overview of the proposed criteria to include Siliq in the product list. The current rules for plaque psoriasis listed in MSM Chapter 1200 contains the necessary information for approval of Siliq.

Dr. England reminded the Board off label use is allowed if there is sufficient evidence showing it is safe and effective.

Dr. Marx asked if we are limiting to FDA approved indications or is the call center’s responsibility to assess the quality of peer-reviewed literature.

Dr. Jeffery responded that indications must be FDA approved, listed in a common compendia or accepted use in peer-reviewed literature.

Dr. England called for public comment.

Dr. Nindhana Paranthaman, Medical Doctor from Bristol Myers Squib, provided information on Orencia including new indications, dosing procedures, study designs and results. Agreed current criteria provides coverage sufficiently.

Dr. England asked if this new indication is included in the criteria already.

Dr. Jeffery responded psoriatic arthritis is included in the criteria. Asked Dr. Paranthaman if the criteria is suitable to the updated indications.

Dr. Paranthaman responded that the criteria does allow appropriate access.

A motion was made to include the new product, Siliq, in the list of products. The motion was seconded and accepted.

* 1. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for codeine and tramadol use in children.

Dr. Jeffery provided an overview of the FDA and American Academy of Pediatrics warning of tramadol and codeine use in children. Utilization reports were included with the binder. Requested age limits of 12 or under be restricted.

Dr. England asked the Board if limitations were added for codeine and tramadol, what would be recommended instead.

Dr. Marx responded most children should not be using opioids. Anti-inflammatories work very well for most children in emergency situations or oncology.

Dr. Slamowitz offered that a lot of opioids in children are used for sleep.

Dr. Marx offered alternative opioids more appropriate for children including oxycodone elixir.

Dr. Jeffery clarified the call center is not doing anything with these because there are not any system limitations currently.

Dr. England suggested having the topic at the next meeting with some specific criteria recommendations and information from other State Medicaid programs.

Dr. Jeffery asked the Board for opinions on what appropriate options should be included in the proposed criteria.

Dr. Marx suggested looking at children’s hospitals for what is used.

Dr. Slamowitz suggested taking the question to Dr. Dimuro for input.

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

Dr. England called for public comment.

No comments.

1. **DUR Board Requested Reports**
	1. Psychotropic medications used for children and adolescents.

Dr. Jeffery presented the reference page of the general population of total enrollees and children enrolled in Fee for Service Medicaid. Data presented for four or more psychotropics. Two years of data is included in the reports and only for children under age 18. The medications being used and presented and discussed. The number of children on two or more agents in the same class was presented. Anticonvulsants are the most common agents used when two or more agents within the same class.

Dr. Bunuel asked what diagnosis these medications are being used for.

Dr. Jeffery responded that diagnosis for use of these medications is difficult to tease out because they are submitted on the medical claim.

Dr. Marx asked if the Board of Pharmacy requires the diagnosis be listed on the prescription.

Dr. Wheeler stated it is only at the patient request.

Dr. Jeffery reiterated how difficult and unreliable matching the diagnosis to the prescription claims is. Multiple anticonvulsant use vs. multiple antipsychotics is a different conversation.

Dr. England posed the question to the Board, would adding a diagnosis requirement add an undue burden.

Ms. Sprout updated the Board on the modernization of the MMIS and getting to the point of having better data set available.

Dr. Owens stated he has a lot of patients who don’t know what their medication is treating. It does take a little extra time to include the diagnosis, but it makes sense for safety and precautionary measures.

Dr. Slamowitz stated requiring labeling with a diagnosis is not something this Board can enforce, it is the responsibility of the Board of Pharmacy.

Dr. England posed to the Board if a requirement for a diagnosis would be a benefit.

Dr. Bunuel stated it would help to know why these medications are being used.

Dr. Slamowitz stated use for the children in foster children is being monitored.

Dr. England clarified the intent is to not restrict utilization, but to make sure it is appropriate. Requested the board look at specific diagnosis before any changes can take place.

Ms. Sprout suggests we look at the percentage of the population that is using psychotropics.

Dr. Marx stated a good database is important for utilization and retro-DUR.

Ms. Sprout responded that the Directors office is focused on meaningful data and is a focus.

Dr. England requested this topic be brought back with some of the information discussed.

* 1. Opioid Utilization – Top prescriber and member

Dr. Jeffery provided an overview of reports including specific strengths and opioid names broken down by member.

Dr. England asked for input regarding using different opioids for short-acting vs. long-acting.

Dr. Marx responded that pain management is a balance of using long-acting agents and a short-acting for breakthrough. Uses more frequent low doses rather than higher dose long-acting which may promote liking. Sometimes a different molecule hits different receptors that can provide a benefit. Patients getting opioids from illicit places is really the problem.

Dr. England stated the usage seems to be logical. Suggests we continue to monitor for opiate use.

Dr. Shea stated the majority of patients appear to be on appropriate therapy.

Dr. Jeffery called out some members using high amounts of methadone. The reports break down the utilization and give a better picture.

Dr. England asked that the Board continue to monitor opioids.

Dr. Jeffery presented the utilization for the top opioid prescribers were discussed. Data goes back two years, changing the names from the last report.

Dr. England asked if there is any red flags for follow up.

Dr. Jeffery responded that much of the opioid use is for dental procedures.

Dr. Marx stated that much of the opioids prescribed by dentals is probably not necessary.

Dr. Jeffery presented the trending utilization of opioids since implementing the new quantity limit on May 15, 2017. Members were grandfathered in who were stable on an opioid. Maybe looking at dose reductions may be the next option.

Dr. Marx responded that doing dose reductions with opioids is misguided and not appropriate.

Dr. England agreed that dose reductions are not a good idea.

Dr. Marx added that blood pressure or diabetes medications are not tapered off.

Dr. Owen stated that there are opportunities to reduce hypertension or diabetes medications if the patient lost weight. The same could be true for pain treatment if they are doing physical therapy or some other treatments.

Dr. Marx stated 95% of opioid deaths are obtained through illicit means.

Dr. Jeffery pointed out another graph showing some downward trends of opioids members and claims since May 2017.

* 1. Gastroenterology studies in recipients with extended use of proton pump inhibitors.

Dr. Jeffery presented the information including medical claims data who have had an endoscopy who are also receiving proton pump inhibitors. The majority of recipients on PPI’s have never been scoped.

Dr. England stated it appears the utilization seems to be appropriate.

* 1. Impact of 90 day maintenance medication requirement.

Dr. Jeffery presented data since the end of April 2017 when a 90 day requirement to fill maintenance medications was implemented. A few requests have been received to override the 90 day requirement.

Dr. England suggests continued follow up on the information would be helpful.

1. **Public Comment on any Standard DUR Report**

Dr. England asked for public comment.

No comment.

1. **Standard DUR Reports**
	1. Review of Prescribing/Program Trends.

Dr. Jeffery presented trend reports, nothing out of the ordinary is showing on the reports. A request for ideas to manage hemophilia is made. Two new hepatitis C medications are now available and included in the antiviral classes.

Dr. England states he doesn’t see a lot of fluctuation in the reports.

* 1. Concurrent Drug Utilization Review (ProDUR)

Dr. Jeffery presented the trending DUR edits.

Dr. England added that not much has changed.

* 1. Retrospective Drug Utilization Review (RetroDUR)

Dr. Jeffery presented the RetroDUR letters and results. The response rate is very low. A stamped postcard was included for physician response.

Dr. Marx suggested receiving responses via text message.

Dr. Jeffery presented a draft letter for codeine and tramadol retroDUR.

1. **Closing Discussion**
	1. Public comments on any subject.

Dr. England asks for public comment.

No comments.

* 1. Date and location of the next meeting.

The date of the next meeting will be October 19th and will be at the Hyatt Place.

* 1. Adjournment.

The meeting adjourned at 7:35 PM.