BRIAN SANDOVAL
*Governor*

RICHARD WHITLEY, MS
*Director*

MARTA JENSEN
*Administrator*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
1100 East William Street, Suite 101
Carson City, Nevada 89701
Telephone (775) 684-3676 • Fax (775) 687-3893
http://dhcfp.nv.gov

# DRUG USE REVIEW BOARD

## Meeting Minutes

**Date of Meeting:** **Thursday, July 26, 2018 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:** **Hyatt Place Reno-Tahoe Airport**
**1790 E. Plumb Ln**
**Reno, NV 89502**
**Phone: (775) 826-2500**

## ATTENDEES

**Board Members Present**
Paul Oesterman, Pharm.D., Chairman
James Marx, MD
Jennifer Wheeler, Pharm.D.
David England, Pharm.D
Netochi Adeolokun, Pharm.D.

**Board Member Absent**
Marta Bunuel, MD
Michael Owens, MD
Yvette Kaunismaki, MD

**DHCFP**
Holly Long, Social Services Program Specialist III
Jodi Patton, Social Services Program Specialist III
Andolyn Johnson, Senior Deputy Attorney General

**OptumRx**
Carl Jeffery, Pharm.D.

**Managed Care Organizations**
Thomas Beranek – Silver Summit Health Plan
Ryan Bitton – Health Plan of Nevada
Jeannine Murray – Anthem

**Public**
Ann Nelson, Vertex
Jamie Tobitt, Vertex
John Sandstrom, Shire
Lori Howarth, Bayer
Ryan Morris, Bayer
Joe Lasky, Children's Specialty Center
Holly Frye, Red Chip
John Scott, Novo Nordisk
Jason Russell, Bioveratio
Bill Robie, NHF
Brian Roeder, Ferrari Public Affairs
T. Carsten, DHCFP
Rebecca Reynold, Abbvie
Paige Barnes, Crowley and Ferrato
Pauline Whelan, Orexo
Betsy VanDeusen, Nevada Chapter NHF
Rob Booth, Allergan
Karen Campbell, Allergan
Amy Roonby, Allergan
James Wilson, MD, UNR
Kelly Gonzalez
Amber Federizo, Hemostasis and Thrombosis Center of NV
Jennifer Roberts, Hemostasis and Thrombosis Center of NV
John Zabukouz, Conduent

## AGENDA

### 1. Call to Order and Roll Call

Ryan Bitton,
Jeannine Murray
Thomas Beranek
Jodi Patton
Holly Long
Carl Jeffery
Paul Oesterman
Andolyn Johnson
James Marx
Jennifer Wheeler

Netochi Adeolokun
David England (teleconference)

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

Paul Oesterman: Is there any public comment?

Jennifer Roberts: I am Jennifer Roberts with hemostasis and thrombosis of Nevada. I would like to review the availability of options we can provide as a carve-out option. We are required to submit annually how we have met over 25 measureable quality measures to remain eligible for grants. As the only Federally designated hemophilia treatment center in the State, we have very high standards of care of our patients and subject to audits for HRSA and the OPA as well and many other insurers. We take our program very seriously, conduct monthly self-audits, and third party audits every two years. All factor sales are considered program income and therefore the revenue is restricted. All revenue generated is required to go back to patient care services for example to overcome transportation services, we offer Uber to all our available clinics.

Amber Federizo: My name is Amber Federizo and I am the co-medical director for the Hemostasis and thrombosis center of Nevada. We provide flights via SouthWest for these patients to be evaluated. That is a completely free service that we provide. This provides a better quality of life and outcomes and no cost to the State. We are able to provide amicable solution to our patients at no charge. Our patients struggle with this medication and some pharmacies do not like to service them. We use contract pharmacies that can provide medications at cost savings by allowing a 3% pass-through pricing. We closely monitor that the patient is able to get their needed medications. We are currently partnering with Aeva health to provide factor in the home and self-infusion classes on a monthly basis. As a carve-out, we are willing to negotiate a lower reimbursement on these medications. We can offer significant savings statewide. When a patient has access to a provider in a timely manner, it reduces the number of visits to emergency departments. We would like to suggest carving-out factor products.

Paul Oesterman: Thank you. I have one question. I understand what you are asking, but I do not think that falls under the purview of the DUR Board.

Amber Federizo: Correct, this is an additional agenda item. We have additional information for the prior authorization discussion.

Paul Oesterman: For us to be able to act upon anything, it must be on the agenda.

Amber Federizo: Correct, and hopefully in the future it could be on the agenda.

Paul Oesterman: Thank you. Any other public comment?

**3. Administrative**

a. **For Possible Action:** Review and Approve Meeting Minutes from April 26, 2018.

A motion to approve as submitted. Seconded. Voting.

Minutes are approved.

b. Status Update by DHCFP:

Holly Long: I am Holly Long with DHCFP. I have a couple of updates. In June, preventative services updated their billing restrictions. I have a website where it is posted if anyone is interested. The instructions are intended to be more clear and easy to follow. It is on the Medicaid Nevada website. On June 28, 2018, Medicaid announced that behavioral health providers are invited to attend the monthly DHCFP webinar. The DHCFP behavioral health unit is inviting provider-type 14, which is behavioral health outpatient treatment, and provider-type 82, behavioral health rehabilitative treatment to a monthly behavioral health webinar. These monthly webinars are intended to provide policy training and education to behavioral health providers. A Q&A forum will be available during the event to get real time responses to provider questions. I also have that link if anyone is interested in registering and they can pass along the information.

**4. Clinical Presentations**

a. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for Hepatitis C Direct-Acting Antivirals.

Paul Oesterman: Just for a little background, this was kind of a homework assignment that was put out by the board at the last meeting, we asked our three managed care organizations to try to work together to make a consolidated approach to the prior authorization and apparently, they have worked at this and have come to no compromise. With that being said, what did you come up with?

Ryan Bitton: It is not that we didn't come to a compromise; we did meet with the goal of seeing if we can consolidate these things. We were doing that. We've had difficulties, having all of our documentation different in the sense of the way it flowed, the way it was set up, all of those have one thing wrong, hepatitis-C and some of us had separate ones by each drug and as we went through the process, we didn't see an easy way. A decent amount of effort from each of our organizations and retooling the processing part of them that need prior authorization or individual states that we cover. We couldn't come up with a pass-through to that.

Jeannine Murray: It's fair to say when we looked at the criteria and we compared the criteria, this is all in a different look or format, but the elements of the criteria are similar. We did like a grid to see who had what and it seems very similar as far as the requirements of the criteria to better read through it; the documents all look different.

(Indiscernible speakers)

Ryan Bitton: The intent of how we covered them is similar to the way that OptumRx covered it so our thought was, we are covering them similarly as per the DUR guidelines so it allows separate documents and support separate processes.

Paul Oesterman: Okay, I appreciate your efforts.

Carl Jeffery: As you know, we have brought these back a couple of times. I have brought forward some proposed criteria from Optum, which is probably unfortunately similar to what the other ones are. After seeing their recommendations from the MCO as saying that they would just like to keep this criteria. Chapter 1200 as it is currently written is confusing and so we are going to go down the road of having individual agents. We still do not have criteria for the two newest agents, Mavyret and Vosevi. Therefore, we still need some coverage criteria for those if we are going to have those covered, as well. It would be simpler for the chapter 1200 criteria to be listed by drug, and that way they're easier to update and easier when a provider wants to treat hep-C; they have an idea of what drug they want to use, they look at the specific guidelines. I think as a reference document easier to use if it's listed by drug. We have all the different proposed criteria listed in the binder; probably half the binder here. The first couple are the OptumRx proposed criteria that is just listed by drug.

Paul Oesterman: I guess at this point, I would ask our managed care organizations, how do you feel about the proposed prior authorization criteria that as listed by drug?

Jeannine Murray: That is how Anthem has it listed. You would look for the specific drug. If you are wanting to prescribe Mavyret, you would go to Mavyret and pull that criteria and that's what you would submit off of and it probably looks very similar to what the other criteria is except for it has a few more genotypes that are available for it.

Paul Oesterman: Okay, so that's Anthem's take on it. How about HPN?

Ryan Bitton: We've got one document with all of them. The criteria is similar, so even though my document may be 20 pages. I'm okay with the criteria that is proposed for Vosevi and Mavyret, but we tend to put them in one bucket.

Thomas Beranek: Ours are similar they don't look exactly the same but as Carl stated, ours are individual, as well, so they look is similar. Silver Summit would be fine with the proposed criteria.

Holly Long: How would the Optum proposed criteria look, does that include, I see Mavyret, but is Vosevi in there, as well?

Carl Jeffery: Vosevi's mentioned, yeah.

James Marx: It would seem to me, since these are pretty complex patients anyway and have a high likelihood of ending up on fee for service regardless, it would seem to me simplistic just to use the Optum that's already a part of fee for service as the managed care organization want to get rid of these patients anyway, we know that, and they not really excited about taking up hep C, so why not just use the Optum criteria from the very start? It looks like a lot of work on their part, and have a unified approach rather than attempt to try to go through the various iterations of who does what and which is preferable to another when they are going to end up in fee for service regardless, why not just start out that way and be done?

Carl Jeffery: Yeah, and that is a valid point. We can look at the utilization so here's the utilization of the different products, this is for fee for service here but you can see, you know, it's hard for me to look around and turn around like that but, here between 5 and 45 claims per month we're

seeing so we're not seeing a whole lot of claims. Here's Anthem's utilization and theirs is formatted a little bit differently.

Paul Oesterman: I think one thing to note also is that the number of claims for the hepatitis C drugs is on the decline, too, because patients are being treated, they are being cured, and so we're having fewer and fewer claims. So at this point, we do have a proposed prior authorization guideline in front of us from Optum. It sounds like our managed care organizations are okay with what's being proposed here. We've gone through this several times. We will ask that the chapter 1200 be updated to reflect by drug. Do we have a motion to approve the proposed prior authorization guidelines, the Optum guidelines for the hepatitis-C direct-acting antivirals?

Motion to accept as presented.

Second.

Voting – Ayes unanimous. The motion carries.

b. **For Possible Action:** Discussion and possible adoption of prior authorization criteria and/or quantity limits for antibiotics.

Jim Wilson: My name is Jim Wilson, I'm a pediatrician in Northern Nevada Hopes. I am also on faculty with the University of Nevada Reno, Department of Pediatrics and Health Sciences and the directives of the National Developing Center. My background is in health security intelligence, I led the teams with substantial intel on the expansion of H5N1. I did provide warning of the 2009 H1N1 pandemic and was involved in the investigation of the Haiti Cholera disaster. About 25 years of history in health security intelligence. My role here today is I'm the co-chair of the Nevada and Civil Stewardship Program. I do have these handouts. I was hoping to provide you all some context as to why we are talking about this in the context of antimicrobial stewardship. The first slide here is that this kind of reviews where we in comparison to the rest of the country in terms of the antimicrobial consumption. We're 15$^{th}$ in the nation overall for all antibiotic classes in the outpatient sector. The next slide is for cephalosporin. We are 15$^{th}$ in the nation and 20$^{th}$ in the nation for quinolone respective. So, that's pretty good. I want to acknowledge the CDCs assessment of our state in terms of consumption. Now we're getting to some of the interesting stuff. The next slide, unfortunately, though we are number one in the nation for carbapenem resistance. Additionally, that is the last functional line of drugs we have to treat gram-negative infections. This is a big deal. We also on top of this do have evidence of (indiscernible) resistance. Some of this is due to infection control issues. Some from reported cases from foreign countries. We are the first State in US history to report the death of someone from pan-resistant bacteria. We are a hot zone for drug resistance. The next slide, this is actual data from our acute care, SNF's. Basically, we have multi-drug resistant e. coli here. Our most common bacteria that we isolated in medicine is multi-drug resistant. It has been so for about 10 years, which means it is resistant to five different class of antibiotics. The trend lines are not reassuring. We do not have statistical evidence yet of the effects of antimicrobial stewardship in our facilities. Next slide, this is what acinetobacter looks like. This is an important gram-negative pathogen for LTACs. If your patient's on a ventilator and you're trying to figure out how to treat them upfront for infection involving the acinetobacter good luck. The cephalosporins, why are we focusing on the third generation cephalosporins? Because we're losing control of our third

generation cephalosporins and that is why it shows that across multiple gram-negative species and streptococcus pneumonia, we are really concerned about our ability to be able to continue using this drug in the acute care setting or long-term acute care setting in a skilled nursing facility. So really what we're trying to focus on here is making sure that we're using third generation cephalosporins in the outpatient environment appropriately. I can tell you as a pediatrician, we are seeing these used inappropriately and the studies have currently shown that. This is really a call for us to be on the same page initially with these drugs judiciously, appropriately, and in accordance with the IDSA guidelines as well as the local intel. Next slide, the fluoroquinolones, if you are trying to get the fluoroquinolones up front to treat infections, better check your cultures and sensitivities. We have some facilities reporting 30% success. We have come to understand that Cipro is used quite frequently and is a frontline medication often inappropriately for things like asymptomatic bacteria, uncomplicated urinary tract infections, again in contrast to what the IDSA recommends so again, lots of inappropriate usage which promotes the development of tremendous resistance. Levaquin is the next one. Levaquin is supposed to be reserved for use in serious bacterial pneumonia. This is where these patients might be going to the ICU and have lost control of that medication, as well. This proposal here is an attempt to help us get control of the problems as an outpatient prescribing behavior. We can use all the help we can get.

Paul Oesterman: I think we all recognize in practice that antimicrobial stewardship has become a leading concern for all of us and I know in my facility, we have dedicated physicians, pharmacists, nurses. It's going to be an uphill battle. It's one definitely worth looking at and I think your advice about possible limitations or guidance for use of the third generation cephalosporins in the outpatient basis is very well warranted. Thank you for sharing that. We have in front of us, proposed criteria for coverage/noncoverage of third generation cephalosporins and the fluoroquinolone, oxazolidinones and Carl I will let you go over the criteria since you've got it.

Carl Jeffery: It's up on the screen here for those who want to see it. I was working with Dr. Wilson. He came to me several months ago with the concern he just expressed here and so based on some of his studies that he's been putting together, put together some simple criteria. Basically, it's fairly simple as far as requiring prior authorization, which our prior authorizations are turned around in 24 hours and so that's faster than cultures come back. The criteria that I proposed and put together was the culture and sensitivity-proven susceptibilities suggest the drug is necessary. And that really is the criteria, there's some exception criteria so if it's prescribed by an infectious disease specialist or cefixime for gonococcal infection or ceftriaxone isn't available or if the recipient resides in one of the following: Acute care, long-term care facility, and skilled nursing. Those would go through without any kind of PA. Right now, we're just starting with the third generation cephalosporins and the fluoroquinolones on specific medications are there. I know this is a big step, this would be a pretty significant impact, but I think it's what Dr. Wilson said, I think it's pretty important in regards to this.

James Marx: Why are the last two exceptions on there, I think that would be more critical than otherwise?

Paul Oesterman: I'll speak towards the LTAC because that's where I practice and we do have the cultures and sensitivities right there so we're on this.

James Marx: It's not all will and some won't so that's my concern.

Paul Oesterman: Well that's where the antimicrobial stewardship team I think will intervene and they do and they are. Joint Commission now has mandated a lot in that direction.

Carl Jeffery: So that's pretty much the proposal. I don't think the MCOs have any kind of suggestions with these.

Ryan Bitton: I think HPN was worried about prior authorization on every antibiotic, but the focus on specific agents makes sense toward antibiotic stewardship. So the prior auth would just require the culture and sensitivity.

Carl Jeffery: Right, they would have to know what bug it is and they'd have to know it's sensitive to the requested agent.

Jim Wilson: So just to reassure you, we really are sticking with IDSA guidelines, we are finding in the field, they are not being adhered to. If you look in Epocrates, which is the number one mobile app for prescribing for frontline physicians, so that's what we're using now. We find that a lot of physicians are just going with whatever they are used to and they're not really taking a minute to just go in and hit the brakes and they're not aware of what is going on in the SNFs or LTACs. Many folks are not getting cultures when they should so this is sort of an encouragement to get back to the standards that we were trained in for medical school, we should have them.

Jeannine Murray: Will there be education or some kind of campaign from other providers on this or will it just be a provider bulletin?

Paul Oesterman: I think this is one that because it is so significant, that a letter should go out to providers.

Holly Long: I do, too. We can definitely work on a letter, we'll always have a web announcement, but regardless of whatever we decide on, we'll provide a lot more detailed information and maybe go to the next step in providing some kind of link for a webinar or provider training that is specific to this and give more detail around the purpose for it.

James Marx: I think this is the first criteria that's coming out totally backwards. You're looking at sensitivity. I say we should be looking at resistance and that there's no other viable products that could be use because there are a lot of garden-variety infections from sensitivity. Some say, well I got a culture and sensitivity, and therefore I could be approved, so I mean that's totally, I don't say ass-backwards but I think ass-backwards. If you're looking at resistance, those are the only suitable treatment rather than on the basis of resistance rather than sensitivity. I would say that that criterion should be revised.

Carl Jeffery: I'll ask our resident expert here, Dr. Wilson.

Jim Wilson: Okay, so the IDSA guidelines, I'll give you an example, uncomplicated cystitis, the number one recommended treatment is Macrodantin, nitrofurantoin, right? That's what should be using with resistance patterns here in the states support that, right? The reassuring

thing is the data is supporting the standard national guidelines, which should have been using anyway, right? So that's the point of reassurance and I do agree that the language should be revised to reflect that we're actually using a couple different data, of course, but we do want to encourage providers that if they feel like they need to pull that particular antibiotic to use on a patient that they would be able to justify either against the IDSA guidelines or that they do have cultures and sensitivity on the patient back. There are times when we don't, we can't get cultures and sensitivities done.

Paul Oesterman: So, possibly to support Dr. Marx's comment, maybe we could revise the criteria. Bullet point number one, to read culture and sensitivity, proven susceptibility and resistance to other agents, suggesting the requested drug is necessary.

Jim Wilson: Susceptibilities does imply that.

Paul Oesterman: I want to cover both ends of the spectrum.

Motion to accept as amended.

We have a motion to approve the proposed criteria with the amendment that I just stated, do we have a second.

Second.

Voting – Ayes unanimous. The motion carries.

Holly Long: Paul, do you mind repeating the amendment.

Paul Oesterman: Sure, bullet point number one is to read culture and sensitivity-proven susceptibilities and resistance to other agents suggests the requested drug is necessary.

Holly Long: And what would you like from, what would the Board like from DHCFP as far as provider information?

Paul Oesterman: I'd say just a letter letting them know that increased support antimicrobial stewardship efforts.

Jim Wilson: I am funded by the State, so I am here to help.

c. **For Possible Action:** Discussion and possible adoption of prior authorization criteria and/or quantity limits for medications used in the treatment of hemophilia.

Paul Oesterman opened up for public comment.

Amber Federizo: (indiscernible). Amber Federizo, Provides overview of services and locations of sites. States an overly aggressive prior authorization process may impede services. But there are some processes that could be put in place to see some cost savings. A factor product that has been negotiated at a special price could be used. They have lost some services to specialty pharmacies. States she is the only dual certified provider in the State. Recently

contracted with the department of corrections and have been able to save them money. Recommends to look at guidelines and implement rules related to those guidelines. Limit prescribing to specialists.

Paul Oesterman: Just one point. Our prevue is not necessarily cost at this committee, so keep that in mind.

Kelly Gonzalez: I am Kelly Gonzalez, although I have had fancy title of PharmD and N.P., it seems like other MBA and (indiscernible) I am a mother. I support and I have some things to talk to you about with consideration to prior authorization guidelines. I wanted to show you slides. I'm just going to show you picture of my daughter a year ago. This is my child that has a severe bleeding disorder. I have 5 children, 4 of which have bleeding disorders. My daughter had to go to the hospital because she broke her arm and anyone that knows anything about bleeding disorder knows that any healing to the bone itself requires appropriate clotting factors and she did not have that. This is my daughter 4 months after her emergency surgery at the hospital, I don't know if you can see that through the bleeding, she had appropriate care. We went to the hospital and in the hospital, she underwent the surgery, right after arriving at the hospital. And what happened, we had blessed, because what happened is that immediately they called and they got authorization because they knew they would need this post-surgery. They were able to obtain prior authorization because of the insurance (indiscernible). Even with that 4 months later, she has a circumference of a 17-inch arm because of swelling and inflammation even with the appropriate medications. I want you to imagine my child and what would have happened to her had she been in the hospital, had they done the surgery, and they called for a PA to have this quantity of medication on hand at the house, when she is released 24 hours later and for them to say she was going to be in for 72 hours, or hey this is going to take another week or this is Thursday and we can't process this until Monday. I want you to imagine that even with the appropriate treatment, she has limited motion and she went through all of the appropriate channels. Imagine if she didn't have access to treatment with the prior authorization being delayed. I have my older child who has two severe bleeding disorders, and her PA's were delayed significantly, and that resulted in us going to the ER. It's about quality of life. It does come down to cost. As you move forward and you're going to decide and talk about prior authorization and what states appropriate time-frame for people with bleeding disorders and our hemophilia community, I want you to consider the quality of life that my children, one of which had even though she had access to treatment right away, she still had problems healing because of her bleeding disorder, and then imagine if you were in my other daughter's place, what she had to go through with the ER. If my daughter that had access, she had to go to the ER every time. As you move forward and you consider adopting prior authorization for these, I want the people in the hemophilia community, this isn't about prior authorization, this is about prior authorization because I needed to a hysterectomy. This is about prior authorization for something that needs immediate treatment, so the longer that we delay treatment, it's problematic to the quality of life for persons like my daughter/my children, I'm not opposed to saying like hey, I know that there is inappropriate use. I'm not saying that there's not, I'm not saying that people should have people should have a lot on hand, I'm not saying that. What I'm saying is that, you know, our genetics dictate to what our bleeding type is, this is what our bleeding disorders are and our genotype is monitored by our provider and this is what clinically presents and this is what we need on-hand. That's not going to change. My diagnosis is not going to change. It's in my genetics. I have the genetics and neither will for my child, neither will it for some on our committee who have severe hemophilia, there is

0% factor level is still 0% factor level. Take into consideration that say we're going to require it every whatever, the frequency might be, take it into consideration that you know, we're not opposed to saying, hey, we'll come in for a clinic and go through a P.A. that you're going to say, well we'll PA you for three months or six months, the quality of life that patients in our situation have and take that into consideration. But I don't understand PA's that take weeks and we have to do every month for every single issue. Thank you.

Bill Robie: Hi, good evening. My name is Bill Robie. I represent the National Hemophilia Foundation. I work in our public policy department. Our organization is based in New York. I work out of my home in Bend, Oregon and cover about 19 states. We submitted a letter for the record expressing our concerns about clotting factors for PDLs and prior authorization criteria so I'm not going to rehash that I just wanted to take a few minutes and give you a little bit of background on our organization and bleeding disorders in general. We are to ensure the individual affected by hemophilia and related to bleeding disorders that timely access to high-quality medical care and services regardless of financial service deficits, were in place for residents. NAHF has a medical and scientific advisory council that issues guidelines for the care and treatment of hemophilia, and their recommendations are for individuals with bleeding disorders, they have to have access to the full range of FDA approved clotting factor therapy as determined by their treating physician regardless of financial circumstance or type of insurance coverage, if they need access to a federally funded hemophilia treatment center providing collaborate integrated coordinated care, and access to at least one specialty pharmacy provider and 340b program. Hemophilia and other bleeding disorders most importantly fortunately are rare conditions. Also, they are inherited conditions. They are genetic. In most cases, it is passed from mother to son but women also have bleeding disorders. I will refer to hemophilia most generally as that's what people are familiar with. The main symptom of hemophilia and other bleeding disorders is uncontrolled and often spontaneous bleeding and internal bleeding into the joints which result in pain, swelling, and even cartilage damage. They are rare conditions. There's about 20,000 people in the U.S. at any given time that have hemophilia. When you include other bleeding disorders, that number goes higher, probably the most common bleeding disorder is VonWillibrands disease, and that is spread equally between men and women in the population. Hemophilia occurs in about 1 in every 5000 births and while in most cases it runs in the family and is passed on, there are cases of spontaneous mutations so there are new cases developing every day. There's no cure. There's also no prevention. If you have hemophilia, you have a disease where you have it your entire life, so treatment is never an option. That treatment is lifelong infusions of replacement by factor therapies. These are from human plasma or using recombinant technology. Many of our patients, certainly the most severe from a prophylactic type of treatment, so they're infusing regularly to prevent bleeds. Those in milder conditions may have the luxury of treatment on demand but most of our severe patients are between prophylactically prevent bleeds to begin with. People did start learning to infuse themselves at about age 7 or 8 and then they spend the rest of their lives infusing themselves so most of our patients are infusing at home, some people infuse, I've seen videos of people infusing in the middle of a lake, so home fusion is the typical treatment standard for most of our patients. We are an expensive population. As been indicated, treatment costs for an average hemophiliac patient is about 350,000 dollars a year. For severe patients, it's about twice that and if you've got an inhibitor, it's probably at least a million dollars a year. The good news is for our patients, if they have access to the medication that works for them, they feel otherwise normal lives, being productive, tax-paying citizens running businesses, having a job, having a family and things like that, case in point, Chris Bombardier, a member of our

community in Colorado climbed Mt. Everest last year and was infusing the entire time in his tent on the way to the summit. So, our patients are very adept to taking care of themselves as long as they have access to the medications.

Paul Oesterman: You have about 1 minute left.

Bill Robie: Again, for most of our patients, the most serious concerns are bleeding at the joints, into the organs, into the brain and as a consequence, people either are not having access to the right medication, they're not having timely access. For many of our patients, our concern about not having the medication prescribed by their physician is they experience some increased bleeding or doesn't control their bleeding entirely; the treatment protocol is more infusions. Some of our patients are not necessarily on proper medications and the result of costing more because of simply infuse more to take care of bleeding episodes. Again, we have a letter submitted as part of the record.

Betsy VanDeusen: I am the executive director of the nation chapter of the National Hemophilia Foundation. Our mission is to improve the quality of life for your members with bleeding disorders. We represent over 600 households and an estimated 60% of our members are on Medicaid. I am here to advocate for our members to have access to all approved therapies for the treatment of bleeding disorders. I am requesting access without undue barriers that may compromise the quality of care or increase hospitalization and ultimately result in higher costs. I request prior authorization criteria to be as direct and open as possible and for as long as a period as possible, six to 12 months. We request additional barriers such as preferred drug list or quantity limits not be imposed due to their documented negative effects of health outcomes. We would be in favor or moving hemophilia treatments to fee for service because it would provide with the most timely access to treatment. As far as what Amber shared, the National Hemophilia Foundations supports the federally designated treatment center model and our stance is that we request to have at least two pharmacy options available to our patients and one be a 340b program. Thank you.

John Sandstrom: I'm John Sandstrom with Shire. We represent a large number of products. Our company manufacturers products for hemophilia A, hemophilia B, (indiscernible). I will not talk about how clotting factors are different. I think my colleagues have already addressed that. One thing that I will point out is that our two products, Advate and Adynovate. Advate is the standard half-life therapy available since 2003 with a full complement of real world evidence study and clinical studies supported. In 2018, the FDA approved (indiscernible), the first and only FDA-approved software device. They're based on a pharmacokinetic model for the management of dosing as well as the interval of therapy. This in conjunction with management of vial sizes can have an impact on the disease state management with respect to cost and efficacy and can be used as part of a disease-state management program. Our extended half-life products, the Adynovate is a factor 8 for the treatment of hemophilia A. I wanted to point out that in a recent peer-reviewed publication, that categorizes extended half-life products, there's a number of products that claim to be extended half-life products. In this article, they categorize Adynovate and some other products as our pegylated form of extended half-life product as an extended half-life product. Also in our profile, with respect to our clinical trials for Adynovate, we have shown to provide a reliable and predictable twice-weekly dose in patients in the trial, when we had to adjust their dose with 2% of the population.

Kelly Gonzalez: I know that you guys mentioned that you said earlier like cost isn't a factor. But I don't understand because why would PA be required if cost isn't a consideration? Isn't the PA required to reduce unnecessary usage and what is…

Paul Oesterman: Unnecessary usage and inappropriate…. You heard about the antimicrobials? Inappropriate use. That's kind of what we're looking at.

Kelly Gonzalez: Because inappropriate use as effective use would be a cost hindrance. From my perspective as a patient, as a parent, it does come back to cost and it does come back to wanting to work with our insurance companies to make sure that the PA that's put in the process, that's for quality of life for patients but at the same time, cost effectiveness. I just wanted to add that part of it.

Carl Jeffery: We'll talk briefly about what we have going here. The Optum criteria is in there. It's very simple. It requires a diagnosis and FDA approved or some kind of other peer review literature and make sure it's appropriately being used, the dose is appropriate, and the duration is appropriate and really there is no quantifying it in our criteria that I put together so it's really up to the provider to say that and the pharmacist will be reviewing the PA. The dispensing provider basically makes a promise that they will monitor how much product that the member has on hand; I've heard horror stories of pharmacies that just drop ship factor regardless of how much the patient may have on hand. We want to get away from that and make sure that the provider is following up with the member and finding out so they don't have that overstocked and then that the prescriber is a specialist in treating hemophilia. The criteria that was submitted by the MCO I think are much more extensive, very specific, so they're good criteria and much more lengthy.

Jeannine Murray: Well I think they're put together by drug and they align with what the FDA lists as approved.

Paul Oesterman: Looking at the proposed criteria from Optum here, it looks like pretty much the diagnosis is required and is supported, the prior authorization covers pretty much every drug available right? Am I correct? On our managed care organizations, all of them are covered, just to confirm. We don't have an issue with drug cost selectivity there. My only question might be in regards to the proposed approval length of just being 3 months? I would recommend a longer period.

Speaker: National guidelines suggest patients under 18 year old see their provider every 6 months and adults every year. So, if they were to extend that to coincide with provider visits, that would advantageous.

James Marx: Prior authorizations keep me working until 8:30 every night, so I think putting unnecessary prior authorizations is just a lifelong process is typically not going to change so I'm not sure why we need; 6 months is a reasonable expectation.

Paul Oesterman: I would go with a year.

Amber Federizo: For continuity of coverage of a year, I would not want to see them not go through the prior authorization for a change in medication. I do see a lot of inappropriate

utilization around the state. I see a lot of money being wasted. I don't think a change in dose should require a new prior authorization, but the initial approval should be for one year.

Carl Jeffery: And the way our PAs work, if they were approved for a single one agent, they could go up and down on the dose for that one agent, but if they change from like Kogenate, to something else, that would require….

Speaker: (indiscernible)

Carl Jeffery: Those PAs get complex. I don't know what the MCOs do as far as when they enter those specific quantities, they're allowed specific….

Jeannine Murray: I'm pretty sure you can find the number of units even though the PA lengthened for a year, but I think the PAs enter by hand.

Paul Oesterman: So, if I'm hearing you correctly, you're kind of not suggesting but asking that we maybe consider limitations of 3% variance…

Amber Federizo: I am asking because as some pharmacies are better than others in how they adjust the dose. A prescriber may not really evaluate the refill request from a pharmacy and just sign it off.

Carl Jeffery: We do have the utilization numbers in there. (slide presentation) This is for the fee for service. It's broken out by product. We have several patients in fee for service that are on hemophilia products. It kind of goes down. AmeriGroup is in there. It's carried over to the next page and so by far, fee for service has way more claims than the MCOs but I think that's most of the sicker patients come to fee for service.

Holly Long: Was there a reason behind Optum proposing the three-month duration?

Carl Jeffery: I'm not opposed to 12 months or 6 months.

Paul Oesterman: What I'm hearing is that the proposed criteria that we have is to amend the approval length to one year from prior authorization and that a new prior authorization would be required for any dose adjustment, and I'm going to go liberal, in excess of 5%, either increase or decrease.

Motion made to approve amended criteria.

Second

Voting: Ayes are unanimous, motion carries.

d. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for medications used in the treatment of irritable-bowel syndrome.

Opened up for public discussion.

Carl Jeffery: Trulance is an existing medication. It's been on the market for a while. It's got a new indication for irritable bowel syndrome so that's why we're just going to add it to our existing criteria or with Linzess and Amitiza. It follows the same steps. In addition to its chronic idiopathic constipation diagnosis, we're going to add the IBS-C. This is the chapter 1200 criteria that is proposed in here. I just copied it over and then added the generic name for the Trulance. That's the only change, just adding because the other ones had a max daily limit.

Ryan Bitton: For HPN, this aligns with what we have already.

Motion to accept the criteria as presented.

Second

Voting: Ayes are unanimous, the motion carries.

e. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for tezacaftor/ivacxaftor (Symdeko®).

Opened up for public discussion.

Speaker: (indiscernible) I am the director of the CF Center for Reno and a pediatric pulmonologist. I would like to thank the Board for considering the prior authorization process for Symdeko and give the patients the opportunity to have this medication in addition to Orkambi. Any questions you may have, I am happy to answer.

Jamie Tobitt: My name is Jamie Tobitt. I am a MSL with Vertex Medical Affairs. I just wanted to introduce that I'm here and will answer any questions. I know how pretty complicated the drugs are, as well.

Carl Jeffery: This is a new criteria because this is a newer medication on the market, similar to the other agents that are currently available. It follows the same kind of standard guidelines that we have set for the other ones. We've got 12 years of age or older, that's what it's approved for currently. They're probably working for younger ages. The diagnosis of CF and then one of the following, they've got the F508 deletion mutations. So this is where maybe it's a little bit sticky because I tried to come up with some language that didn't list out every single mutation because that's what we struggle with is the added new mutation, we have to bring it back to the Board and add that to the criteria. I tried to add language that would include all the mutations as they are added and so I put language in there so if the patient has one FDA-approved package insert listed mutation on at least one allele of the CF transmembrane conductance regulator. I try to get that so read through that and make sure it makes sense. That's my own language so I won't be too offended if you want to make some updates to that or anything but prescribed by or in consultation with the pulmonologist or a CF care specialist, somebody affiliated with the CF care, and then it will be approved for 12 months. The reauthorization criteria is on the very bottom of the page. It's kind of hard to see, but basically it's just documented benefits they are getting from the medications.

Holly Long: I think we're on the page mostly with the MCO's and I apologize I didn't make my charts with the comparisons for the MCOs and the fee for service, but there are different durations. For example, Silver Summit and Fee For Service, we're seeing the duration for treatment early approval of the prior authorization being either 6 or 12 months, is there any information around that why it should be six or 12 months?

Carl Jeffery: I had suggested 12 months because I think that's what we have for the other ones, but I don't know, is there some reason you guys have 6 months versus 12 months.

Tom Beranek: I don't know, I couldn't respond why. If this is the corporate policy, it isn't one we did for this account.

Ryan Bitton: HPN normally approves things for 3 to 6 months initially, we have the authorization criteria still in the reauthorization, then we will go to 12 months to make sure it is effective.

Paul Oesterman: So, for consistency, should we consider our initial authorization to be a 6-month period and then additional refills and reauthorization be 12 months?

Speaker: I would suggest doing it for the 12 months' duration rather than the 6 months' because we do know that these medications are really expensive and we do not start these medications unless they really as a provider that they will really benefit the patient. So, not having to go through the process for 12 months would be really beneficial, I would like to ask the board to consider 12 months.

Paul Oesterman: I guess this is a question from my end, if we approve it as 12 months and your criteria is 6 months…

Holly Long: It's updated. Their criteria can't be more stringent.

Paul Oesterman: They can't be more stringent than we are.

Holly Long: They'd have to change theirs.

Paul Oesterman: They have to change. Okay.

Holly Long: Part of the reason that I ask is as I'm looking at other states like the other states that have the prior authorization, most of them have 12 months.

Motion to approve the criteria as presented.

Second

Voting: Ayes are unanimous, the motion carries.

f. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for ivacaftor (Kalydeco®).

Opened for public discussion.

Jamie Tobbit: Jamie Tobbit from Vertex. We also make Kalydeco, so I am here for any questions. The FDA indications are spelled out in the package insert and this medication should only be used in patients with those mutations.

Carl Jeffery: This is real simple, just like the Symdeko, uses kind of the similar language and just updated so instead of listing every single gene mutation, in reference to FDA-approved package insert so that's the language that was added in there.

Paul Oesterman: You're going to modify and take this out?

Carl Jeffery: Well, that's Amerigroup's criteria. I guess they'll have to take it out. The list of all the gene mutations.

Jeannine Murray: Aren't those the same?

Carl Jeffery: They are and in reference to the FDA. It doesn't have to be in there.

Jeannine Murray: We're not more restricted by them.

Carl Jeffery: Right, so you can have them in there. This is my criteria here. This is the only thing; this is the chapter 1200 criteria here and all I did was remove the… There were a lot of mutations that were listed there and I just changed to list it in the FDA-approved package insert.

Paul Oesterman: This one piece I've noticed is not on here is the renewal.

Carl Jeffery: Yeah and since this was an old chapter 1200 criteria, we can add renewal criteria on there to say the patient had similar to the Symdeko and there's a clinical benefit.

Paul Oesterman: And that would be for 12 months, also?

Carl Jeffery: Yes.

Paul Oesterman: Do we need this to be prescribed by a pulmonologist or specialist, also?

Carl Jeffery: I think it's a good idea. Like I said, we've got an opportunity to update it and we might as well add that same language to it and the Symdeko and we can add that criteria, too, so pulmonologist and specialist affiliated with the CF care center.

Paul Oesterman: We have in front of us the proposed criteria with two modifications. One is the who can prescribe it and the second is the approval line for reauthorization if a patient shows a positive clinical response.

Motion to approve criteria as amended.

Second.

Voting: Ayes are unanimous, the motion carries.

Holly Long: I just wanted to clarify on Carl's statement that a reauthorization is for the one year duration?

Paul Oesterman: Correct.

g. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for topical immunomodulators.

Opened for public discussion.

Carl Jeffery: We have a new agent in this class, which it's been a long time since we've seen a new agent in here, but Eucrisa is wildly popular topical immunomodulator and we see quite a bit of it. If you look at the utilization numbers on there, we're actually seeing it quite a bit. You can see on the popularity of it going up. So the Eucrisa is very popular lately. This is the chapter 1200 criteria existing. We're just going to add the Eucrisa on there. It's also has similar indications, mild to moderate atopic dermatitis for 2 or more year old.

Paul Oesterman: Do you know if there's any head-to-head studies between Elidel and Eucrisa?

Carl Jeffery: I'm not aware of any but I can almost guarantee that there's not.

Paul Oesterman: Eucrisa does not have a black box warning.

Carl Jeffery: Yeah, I don't know that off the top of my head.

Paul Oesterman: I don't think so.

Holly Long: I don't see any black box warnings with this.

Paul Oesterman: Okay, thank you.

Speaker: Under A, the patient must have a failure of a topical steroid. Is there a timeframe associated with that? Like within 6 months they have tried and failed a topical steroid?

Carl Jeffery: Right, and you want to quantify, like how long they need to try this, maybe they tried it for a day, maybe they didn't have good results within a day so they wanted to… No, I think that's good. I don't know what a good 10 days of therapy or something? Two weeks?

Paul Oesterman: Fourteen days.

Carl Jeffery: A 14-day trial within the last 6 months?

Speaker: Yeah.

Paul Oesterman: So, we've added to the proposed criteria that the patient must have a therapeutic failure with the use of a topical steroid for 14 days within the immediate prior 6 months. Do we have any other proposals or changes?

Motion to accept as amended

Second

Voting: Ayes are unanimous, the motion carries.

h. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for compounded medications.

Opened for public discussion.

Carl Jeffery: This is a new one and a new set of criteria for us. This is something we've been a little bit struggling with for the last couple of years because there's a lot of . . . I think it kind of comes in waves and pharmacies that do this compounding, it will compound a lot of stuff that's kind of similar to commercially available stuff but they tweak it just enough to get by the rules. We're an advantage within Medicaid and this may change in the future is that the manufacturers that make like the powders, like the PCAA and Letco and those types of companies, they don't participate in the Federal Drug Rebate Program so we don't pay for most of these anyway, so a lot of what is billed is the pharmacies only get a portion of the ingredients because they're only getting paid for what is rebatable. But, to head these off, I think to get with it, there are a lot of inappropriately used that are still used tablets and capsules and use those in compounding and get reimbursed for that when they probably should not be compounding it, so here is the criteria here. You can read through it real fast but it's basically that each ingredient is FDA approved because we see there's a lot of ketamine being used now and some others, topical Ativan that is being applied. I'm not sure it has any data to show that it's effective, so it's FDA approved, or National Compendia supports its condition, the therapeutic amounts are also listed in the National Compendia peer review literature.

James Marx: I think the specific amounts but also the combination, we're seeing all kinds of crazy combinations and there's not any peer review support for those combinations. I think that may be an out as well, because I mean, there's all kinds of stink oil preparations that are being done. It may be a great idea, but it's not really supported by any sort of science. So, I think that's part of it, too, some sort of support or the combination.

Carl Jeffery: Therapeutic amounts and combinations are supported?

Speaker: Yeah.

Carl Jeffery: And then any prescription ingredient requires authorization and/or steps so if there's not a way to get around the PA for other medications by just compounding it and cannot include any drug that has been withdrawn from the market due to safety reasons or the patient has tried and failed therapy or had a tolerance to two FDA approved commercial available prescription therapeutic alternatives and it then lists out….unless one of the following criteria, and it has some exceptions there, so if they have an allergy or if it's not commercially available

for example, and then the compounded drugs must not be used for cosmetic purpose, and the last one is the compound is subjected to drug specific targeted compound program, they meet all the specific drug criteria below. The last sentence doesn't make sense now, but it made sense when I wrote it. I think it's a remnant of the criteria that I was kind of plagiarizing. I would just strike that number 7.

Paul Oesterman: Did we have a list of commonly compounded…

Carl Jeffery: There's utilization numbers in here of what medications are being used. Ora-Plus Interestingly enough, it's not rebatable but we got an exception from CMS to cover that one because so many children's medications are being used to compound and the next is lidocaine and then again another Ora-Plus similar, so really not too many and we don't see a whole lot of the real high-priced ones here because like I said, most of them are non-rebates so we don't pay for them.

Paul Oesterman: When looking over the list, it looks like a lot of them who used a compound and things like Magic Mouthwash or GI cocktail… Diclofenac gel, that's available from market….That's available commercially, 1%. Interesting that we, Cialis, Viagra, Revatio.

Carl Jeffery: I think those are mostly used, they are compounding them, I hope, is that they are using those for PAH in children.

Holly Long: So Carl, originally when we talked about this, we talked about the dollar amount correct?

Carl Jeffery: And we can certainly go down this path. I know we've talked about cutting just claims over 500 dollars. I am not opposed to having it applied to all of them.

Ryan Bitton: For HPN, we have a $200 limit. So, anything less than that, it isn't worth the PA effort. We have had $50, but we are at $200 now.

Jeannine Murray: Amerigroup has also moved it down over time, we are at $200 now too.

Holly Long: That's what I saw across this board was a lot of the states started higher and then had to move it down, and so generally I think the average that I found was around 200 and they're starting to move it to 100 which I believe Silver Summit is at 100 right now.

Jeannine Murray: You asked about how many claims we had for 500, for compounds; do we have any compounds claim, but we had only 19 over $500, so they are able to get it. They just need a PA for it. We don't have specific criteria, they just submit a universal request.

Ryan Bitton: For HPN, we also reference the FDA do not compound list. And the FDA not approved for topical use. I'm not sure how expansive you want the criteria. We have it there to help guide the pharmacists and providers. I don't know if that is viewed as more restrictive, they are FDA lists that guide compounding. As we move forward with more or less-restrictive, it might help to align it, so something to consider if we have to take it out.

Paul Oesterman: In particular, one of those in here is Prograf or Tacrolimus. As we move into USP 800, the facilities are going to be able to compound that are going to be extremely limited and I would not want to see claims from John's Independent Pharmacy for this when they're not going to be able to safely process these prescriptions. We see a fair amount of tacrolimus suspension but because of the carcinogenic risks, USP 800, pharmacies are not going to be able to compound it unless they have chemo hood and all the requirements to handle that.

James Marx: I don't see a distinction here between sterile injectable vs. oral or topical compounding. I think that's really an important distinction that maybe these need to be addressed, as well, especially with 504 c and d going on and all kinds of problems with compounding sterility issues. I think we really want to make sure that the pharmacy that's doing this is really properly certified to produce that actual product.

Carl Jeffery: Yeah. We only look at oral and topical utilization for this report, but I think you have a valid point there, too. Although, the Board of Pharmacy may have more power over the pharmacies to enforce that.

James Marx: I know that there's a lot of controversy about how well Boards of pharmacy can do that sort of oversight.

Carl Jeffery: Yeah, because there's also the USP 797, I think it's the rule that makes all the compounding the sterile…

Paul Oesterman: That is changing the USP 800, next year. So, we have in front of us criteria that will be recommending the approval of 6 months unless the provider requests a shorter length of therapy, and we have 6 different criteria. We've amended criteria bullet point number 2 to include the therapeutic amounts and combinations are supported by National Compendia or peer review literature for the condition being treated. My question, I've heard talk about a dollar limitation, and I know that's not under the purview of this committee to necessarily talk cost of medication. It sounds like they are dropping, so…

Carl Jeffery: The limits are dropping.

Paul Oesterman: The limits are dropping.

Carl Jeffery: I think as far as this goes, you can't make any decisions to PA drugs based on its cost. I think is what the rule is. So, I think you setting a dollar limit is okay.

James Marx: For example, the number 2 drug in the over 500 list. The 2% is not a whole lot more effective than the 1.5% or Omeprazole 20mg capsule, what do you need to compound that for?

Paul Oesterman: Oral suspension; the patient has a core track and they can't…

(indiscernible speakers)

Paul Oesterman: I think they use that to compound; that's what they use to compound suspension.

Carl Jeffery: And mixed with bicarb and that, especially my daughter was on a PPI when she was an infant.

Holly Long: I get calls all the time from parents that are trying to get certain compounds approved just by the pharmacy to get them to make it because they have complications, they have problems with it, and they're just trying anything so the child won't throw up or the child won't have side effects, sometimes it is the suspension that works and sometimes the tablet, you never know.

Paul Oesterman: On the fee for service slide, what are the row labels, what does that stand for?

Carl Jeffery: So, the top one is the topical, oral, so ex. is external, ij is injection and iv…you know, and OR is oral.

Paul Oesterman: XX is unknown?

Carl Jeffery: Yeah, they didn't specify it, kind of unknown.

Paul Oesterman: Do we ever claims for bio-identical hormone replacement therapy?

Carl Jeffery: We probably do but they're not paid because they're all non-rebate.

Paul Oesterman: I think this is still a pretty vague area and I know this is our first attempt to try and…

Carl Jeffery: If you read through, and I didn't honestly look at the MCOs criteria, I was just reading through the one of the United Healthcare ones next in line after ours, and this is just the first one I came to… I think it's very complete.

Holly Long: HPN definitely has a good middle-ground.

Carl Jeffery: It's the one titled…it's got United Healthcare on the top.

Paul Oesterman: Out of curiosity, are you finding that your claims for compounded medications are coming from necessarily limited number of providers and /or pharmacies?

Ryan Bitton: I think the answer is yes, but I don't have an official report. We normally see pharmacies that do more marketing and some issues. We see specialized pharmacies.

Jeannine Murray: I thought it was interesting when we looked at the, and the names are hidden, but there are two pharmacies that really stick out and there's really not prescribes that stick out as much the way the couple pharmacies do, it would be interesting if we can go back and see what those pharmacies are filling.

Paul Oesterman: And if it's the same limited number of compounds they're specializing in….

James Marx: I like the HPN criteria. The only question I have, the one issue is under 6B about, sentence 1, not intended to treat dermatologic conditions, scar treatments are considered cosmetic, I would say that that's generally true if you're talking about adults but if you have a child that has like a big gash on their forehead, I wouldn't really say that child is vain and wants to reduce the scar, so I think there has to be some sort of wiggle room in there for certain cosmetic sort of indications that maybe are outside the box, maybe let's say an adult, but I don't think they considered that at all.

Ryan Bitton: We have considered it but I think there might be a prior authorization override or something like that that we could have done…

Paul Oesterman: So, we have our Optum proposed criteria here with one modification and then possibly the addition of a cosmetic use for patients under the age of 18 as a waiver. This is relatively new to us and I'm sure we will be coming back to this and revising it to adjust as needed.

Carl Jeffery: Right, and then I would I think just for the call center's sanity, if you would also consider a 200-dollar limit so it would only apply for total claims that were over 200 dollars.

Andolyn Johnson: Since this is my first board meeting, I want to be consistent with what you all done in the past, but at what point we've made a lot of changes do you say, okay, we're going to wait on this and then come back to it after it's republished, because I'm just looking at it from a notice standpoint. I think in my gut, we're on the edge, but I want to be consistent with what you've guys done in the past so are you guys comfortable…

Paul Oesterman: Yeah, I don't think we've made really any major significant changes so… Thank you for your input.

Holly Long: It is new what's going along with what you're asking. I think I have more comfort in it knowing that when we do something like this, any changes that we make that Optum is going to go with it and watch the utilization and too many changes, no matter how much of a change we make if it doesn't make sense in the future. For example, if that 200-dollar limit isn't working, we can change that and we can bring that up at the next meeting.

Andolyn Johnson: Okay, great, thank you.

James Marx: Can we continue to monitor this…

Carl Jeffery: Yeah, we'll watch these and we'll include board request reports going forward at the next meeting.

Motion to approve the proposed criteria as presented with the two amendments and the elimination of line 7.

Paul Oesterman: Motion presented. The only discussion would be to bring the usage back to the next meeting so we can take a look and see, when's this going to be implemented? A couple of months, so like in two meetings from now, let's put it on the agenda to take a look at the usage.

Second

Voting: Ayes are unanimous, the motion carries.

i. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for neuromuscular blocking muscle relaxants (botulinum toxin)

Opened for public discussion.

Karen Campbell: My name is Karen Campbell, PharmD, and Scientific director at Allergan. My testimony is specifically to address the criteria for coverage of Botox on botulinum toxin A (indiscernible). Allergan respectfully request the Board adopt the PAs criteria for chronic migraine coverage as stated in section 10 and 11 in the Nevada Medicaid botulinum policy. The Washington Medicaid criteria for chronic migraines are included in the policy only as a reference. However, if the Board is asked to consider adding the Washington Medicaid criteria for Nevada's Medicaid policy for chronic migraine coverage, I would like you to add the following comments: My first point is, Botox is the only toxin FDA approved for the prophylactic treatment of chronic migraines in adults. We agree that the United Healthcare policy statement included in the binder that the other agents are unproven and not medically necessary for the treatment of chronic migraines. There are three components to the Washington Medicaid Chronic Migraine Criteria. We will go through each separately and provide evidence against the addition of these criteria. Criteria number 1: The patient cannot continue treatment if "have shown an inadequate response to treatment defined as less than 50% reduction in pain per month after 2 treatment cycles." A post-hoc hoc analysis in 2017 provided data on patients that did not achieve the 50% responder rate after 2 cycles of Botox injections. It showed a significant decrease in severe pain days, these treatment refractory patients achieved significant treatment improvement from Botox even though they didn't meet the 50% responder rate criteria. The second criteria: Patients cannot continue treatment if "a change of episodic migraines as defined by 50 headache days per month for 3 consecutive months." The Washington Medicaid final revision release on July 15, 2018, a week ago, has removed this language. The treatment induced by the chronic migraine patients are still chronic migraine sufferers. Lastly, Washington Medicaid limits Botox use to only 5 treatment cycles, one year of therapy. Their policy does state that additional treatment cycles should be the plan's decision. A real-world open label study demonstrated the sustained headache free days through 9 treatment cycles, 2 years of Botox. This real-world study also shows continual improvement in functional disability, reduction in headache impact scores, and favorable long-term safety profiles with only 18% reported having 1 or more treatment-related adverse event. Neck pain was the most commonly reported side effect at 4%. There were no new safety signals identified. Once again, Allergan respectfully requests the Board adopt only the chronic migraine PA criteria for Botox, as stated in sections 10 and 11, and that the Washington Medicaid Criteria only for reference purposes.

Carl Jeffery: This was actually a request from the state. We've had the criteria in chapter 600 right now but the chapter 600 wasn't….

Holly Long: Administration says this is kind of inappropriately placed. It's there but they would like pharmacy to oversee the policy so they've asked that we would move it over to

chapter 1200 and there will be a reference within 600 stating the location of the policy. We didn't see any changes needed for the policy but I don't know if Optum has any recommendations or any of the MCO company recommendations for the policy.

Carl Jeffery: Yeah, and I didn't put any proposed changes in there. My thought was just to move the criteria directly over from chapter 600 to chapter 1200 without any changes, and that criteria is in the back, the last couple pages; it is in the back. None of this criteria addresses migraines?

Holly Long: Yes, it does.

Carl Jeffery: Oh it does. I see it, okay, yeah.

James Marx: Do we have the Washington mandates?

Carl Jeffery: No, I think that reference, and that's what I was talking to Janine about….

Jeannine Murray: The Washington reference is an Anthem policy. Anthem Washington has specific mandates to use with Botox so our policy said Washington Medicaid is not going to follow what the Anthem policy that you go all the way to the end of policy with what is Washington Medicaid's policy for migraines, and I think that's what the lady was referred to. So, we're not here to talk about Washington's policy. This is about in our policy so that we don't have to have a separate Washington policy.

James Marx: I think that's totally wrong. Having used Botox for 20 years, they don't get a 50% reduction but there is an improvement to quality of life and reduction in intensity and severity and frequency, about maybe 50% is an artificial benchmark that really isn't necessary.

Jeannine Murray: When she was referring to items 10 and 11; that was what our policy is and similar to yours for 15 days, how you define migraines.

Paul Oesterman: So, the proposal is just to move, make no changes to the botulinum toxin policy, it's just to move it from chapter 600 to chapter 1200.

Holly Long: Yes, so pharmacy will be managing it.

Paul Oesterman: It looks like our usage is like light…

Carl Jeffery: No, we don't see a whole lot of usage of this, even within the past year, 864 claims total for all of it so it's not a huge utilization of that.

Paul Oesterman: Do we have a motion to adopt the existing criteria from chapter 600 into chapter 1200?

James Marx: I still…I don't have a problem with 10, but I do have a problem with 11.

Carl Jeffery: That's Amerigroup's policy so a few more pages, you've got to go the other way… chapter 600. Prior authorization is not required. So under C? We're going to change that, too? And right now we don't have prior authorization.

Holly Long: Yes, so that they would require removal of it. If it was under pharmacy, it would require a prior authorization.

Paul Oesterman: So, we would be amending the criteria to say prior authorization is required and then how long do we want to make the prior authorization for. Twelve months?

Carl Jeffery: It really depends on what they're using it for. Sometimes it's a one-time administration and sometimes it's chronic.

Paul Oesterman: How do you guys handle the time frame?

Jeannine Murray: I think it's for 6 months. We cover Botox under our medical benefit.

Paul Oesterman: Six-month initial and then reauthorization at one year if somebody has to continue on it?

Ryan Bitton: It doesn't go to a year. We are six months for both.

Paul Oesterman: Six and six? Okay.

Jeannine Murray: It's 4 to 6 from the initial and then ongoing from there.

Paul Oesterman: The call center, which works best?

Carl Jeffery: Either way, it does depend on (indiscernible).

Paul Oesterman: On behalf of our practitioners that are having to get in trouble by the PA process, I know what the answer is 6 months and then 1 year….

James Marx: Yeah, I think that's fine. I think the only thing I really have trouble with is I think the Botox is very misunderstood molecule. It has other effects outside the neuro-blocking activity that isn't addressed here. I wouldn't be using these criteria, but I do use them for some of the central effects. If a provider wanted to use them under a different circumstance, there is no allowance for the use. I'm ok with the use as they are.

Paul Oesterman: So we need a motion to shift the criteria for botulinum toxin from chapter 600 to chapter 1200 with the change and policy of part C from prior authorization is required now that it is no longer not required and the initial prior authorization would be 6 months and reauthorizations would be good for one year.

Motion to accept as amended

Second

Voting: Ayes are unanimous, the motion carries.

j. **For Possible Action:** Discussion and possible adoption of prior authorization criteria for opioid containing cough preparations.

Opened up for public discussion.

Carl Jeffery: I will give everybody a few minutes to read through the extensive criteria that I put together. The patient is a routine, so there's no allowance at all for this for under 18.

Paul Oesterman: The approval length, that would be my only question.

Carl Jeffery: So, there wouldn't really be a length because there would be an age restriction so as long as they're over 18, there's going to be the other criteria that we still have for all of the opioids so either the morphine equivalent dose or we put the codeine with promethazine quantity so they just have to follow those quantity limits and numbers. So we probably don't need the length of 6 months. There's no prior authorization with age restrictions.

Paul Oesterman: We do have a motion to approve. Do we have a second?

Ryan Bitton: Before we vote, can I throw out some MCO criteria? We limit it to a 30-day approval. We define limitations of 120 ml per fill and 360 per 30 days and require a failure of some non-opioid-containing cough syrup. At the end of our short-acting opioid protocol, so it's a little bit more extensive for 12 years of age for codeine containing products. I think there's a little bit more that could be put into the criteria like this. With the opioid crisis, we have some extensive programs and we try to not let kids get opioids. So we built a tougher approval for kids.

James Marx: Well, I think the opioid containing cough syrups is not the opioid crisis, it just hasn't been shown to be safe in kids. So opioid crisis or not, these are not safe in this population.

Holly Long: We do have the existing criteria for codeine for children that we put in place last October. The recipient must be 12 years of age or older… We do have that which takes precedent over as far as a different kind of limitation.

Ryan Bitton: Does it talk about non-opioids first and put limits on it?

Carl Jeffery: Yeah, we did that for both tramadol and codeine.

Holly Long: I have never seen prior authorization for 30 days. How does that work?

Ryan Bitton: There's not a lot of requests for opioids containing cough syrups now. We see the utilization drop off. I have not heard of anything.

James Marx: I think what we're doing is confusing and expectorants, they are two different things; I think we're getting off track here.

Paul Oesterman: At this point, we do have a motion to approve the criteria as presented. Do we have a second? Any further discussion on this motion which is just that the approval length would be for 6 months and the patient must be 18 years of age or over to receive an opioid cough medication without any quantity limitations.

Carl Jeffery: Well, not without meeting the previously established criteria.

Ryan Bitton: To be clear, so with the quantity limits, those were previously established?

Carl Jeffery: Yeah, previously established quantity limits so it various so the promethazine with codeine has quantity limits. There are other opioids who already have quantity limits so if they are getting something that has codeine in it, there's a limit to it.

Paul Oesterman: Do we have a motion and second.

Motion to accept the proposed criteria.

Second

Any further discussion? Seeing none, call for the question. All those in favor of the proposed opioid cough medication new criteria for patients requiring them to be 18 or over, please indicate so by saying "aye." All opposed say "nay."

Voting: Ayes are unanimous, the motion carries.

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

No public comments.

**6. DUR Board Requested Reports**

a. Pharmacy lock-in program:

Carl Jeffery: Holly put together the first page in there. It's the lock-in program comparison name; it compares the different programs and what their lock-in procedure is.

Paul Oesterman: For those in the audience not aware, the lock-in program is a program that requires recipients to obtain their pharmaceutical products from a particular pharmacy so that we try to minimize the pharmacy shopping, the doctor shopping, and the potential for abuse, misuse, and inappropriate use of their medications.

Carl Jeffery: I'll let Holly highlight these and then the biggest differences you will notice.

Holly Long: Sure, well I think the main reason, you wanted to be able to see all of the differences here and wanted to readdress the possibility of reviewing the clinical review after a recipient had been in the lock-in program for a certain amount of time. So, I created this so that you could see what the fee for service does compared to the MCO's, so the review is at the

end of the report. The fee for service is not currently doing a review and the MCOs are; they have their own criteria. One of the biggest differences is with HPN and their Holy Trinity that they refer to that Ryan can explain. Otherwise, they are fairly similar. There's much more detail in Silver Summit's, but I think everybody has the similar clinical review process and everybody is locking into one pharmacy and is everybody is given the opportunity to change the pharmacy? There's some differences in days but duration of time…

Ryan Bitton: Holy Trinity has kind of fallen out of favor. It was a national initiative and that is what it was called at the time. That is basically three medications used.

Carl Jeffery: Wasn't historically the Holy Trinity opioid, Ativan, and Soma?

Paul Oesterman: The Las Vegas cocktail.

Holly Long: I just talked to Kelli Wedge. She is the registered nurse that oversees the actual clinical review for every single recipient for the Lock-In Program. She is very against doing a review again. She doesn't think that there's any point in reviewing the recipients after a period of time, that they should always remain within the lock-in program indefinitely as long as they are a Medicaid recipient.

Carl Jeffery: So, you're forcing the members to go to one pharmacy. Of course, after 6 months they're only going to be going to one pharmacy.

Holly Long: So basing that off of good behavior, it's hard for us to justify that because you're forcing us to be in good behavior, it seems like it would be adding a lot more work for her to be able to re-review, and she does a really extensive clinical review every time.

Paul Oesterman: How often is she doing it? Like once a year?

Holly Long: We're not re-doing a review. We're keeping them on it indefinitely.

James Marx: When did she start doing that because actually I had two patients on lock-in and to this day, I still don't know why they were on lock-in, but I was always amazed why they would be on lock-in and the fact that their pharmacy would occasionally be out of stock, and we had to go to another pharmacy but…

Holly Long: It wouldn't be based on override but just because they are requesting the override.

James Marx: They would have to request it. Some of the pharmacies don't want to do it, there's a lock-in, because they think oh, there's a lock-in, you're a bad patient and most of these cases, they were not, I've never really understood why they were locked in but…

Holly Long: I mean, we could definitely touch base for a number of reasons and take a look at who the recipients are to validate it.

James Marx: One isn't on Medicaid, but the other is still in lock-in.

Holly Long: We can always ask for a re-evaluation if there are certain circumstances like that, and you can do that, and make sure that that happens and there's always an appeal process if the recipient wants to go through that. So, if for some reason they feel like that decision was not appropriate, there is a period of time where they have an appeal process, but we can definitely look at that.

James Marx: It definitely wasn't appropriate and I just wondered if that was just an isolated incident or if there are others, that was my concern. Both these cases, there were no indicators of abuse.

Holly Long: We would have to look at their specific case and see why. And Kelli keeps good records, so we could definitely do that and see if there's…

James Marx: I think in retrospect, we need to look at those patients and see how those came out.

Holly Long: You're the first person honestly that has come forward and said there's someone inappropriately placed. I appreciate your feedback. I'm happy to look back and re-evaluate it.

Paul Oesterman: So is Kelli overwhelmed or can she handle more patients?

Holly Long: Well, she is always willing to evaluate a patient, she just doesn't see any justification in re-evaluating them because we're forcing them to have that good behavior.

Paul Oesterman: Have we put anybody in the lock-in program recently? It's ongoing?

Carl Jeffery: Yeah. We add maybe 20 or 30 every month.

Paul Oesterman: Okay, perfect. That's my question. Thank you for the information. Anybody have any comments on the Lock-In Program?

Dave England: I'm just kind of curious of how well it's working and what the process is but sounds like it's working.

b. Opioid overdose deaths:

Carl Jeffery: This one is not in your binder it was a handout that I put out before the meeting entitled the Department of Health and Human Services Office of Analytics, Opioid-Related Overdoses and Deaths. For some reason, when I put the binder together initially, I could email it but when I added this one page, it put it over the limit and my email system was not sending it out. The one page must have been too much.

Holly Long: We're hoping this will teach Carl a lesson that no binders should ever be this big. So previously the Board had for the opioid-related overdoses and deaths. We're trying to compare between before quality limits and criteria were implemented in May 2017 to after and had some difficulty pulling information because we can't get toxicology reports clarifying what the cause of death was for a period of time usually from these 6 months. So, I apologize. I don't think this data is great. It is for a limited amount of time so what we're looking at is the

best that I can do. We're comparing an even amount of time before and after the implementation so we're looking at 8 months before compared to 8 months after. This is the information that DHHS was able to pull together. This is combined fee for service and MCO data so it's collected by the Department of Health and Human Services and their data analytic team. Just a few things for clarification. The opioid-related deaths on Medicaid, that is the number of deaths with drug poisoning with opioids listed as a contributing factor and those people had to be actively enrolled in Medicaid at the time of their death and then on the third table, this is Medicaid recipients who had an opioid-related overdose on the Medicaid claim and who had an opioid death. There are people who did not have a Medicaid claim with the diagnosis of opioid-related overdose who died due to drug poisoning where opioids were a contributing cause.

Paul Oesterman: This does not necessarily mean they were prescribed for them, but they consumed….

Holly Long: Yes, and I know we're trying to be able to pick that apart and identify that but it's hard to do. So, what I would like to do, I suggested that we can look at it in the future which I think we will have better numbers and an amount of time this works when the CDC reports come out, that those are going to be the best for us to look at and looking at least 12 months of time. But at least we have a start here.

Paul Oesterman: I think this is good information. The numbers are relatively small. I don't think there's a statistically significant difference between before and after and like you say, let's give it some more time to take a look and see because I think as we move forward, there's enough awareness of the opioid crisis that hopefully we'll see a reduction in the opioid-related deaths. Thank you for your efforts.

c. Opioid Utilization – Top prescriber and member, including more than four concurrent opioids

Paul Oesterman: We have a report here. Are there any significant changes?

Carl Jeffery: Yeah, we have a new number one. I don't know if it's good or bad. Several months ago, we sent out letters to the top ten prescribers that were on this report just to let them know. There was the one of the nurse practitioners in Las Vegas who had actually responded with a letter kind of justifying some of their prescribing habits which was good feedback. The instances have decreased. You can see going down in the bottom one here 218 claim or members and almost 2200 claims down to under 1000 and now they're under 1700 claims I don't know. I hope it's a good sign that they're seeing or maybe they're just not seeing Medicaid patients anymore so it's hard to say if it's intended consequences of this but we've got another anesthesiology specialist who is a D.O. in Henderson that's now moved up into number 1and they were number 3 before on that graph before.

Holly Long: So, the one that's number 1 now receives the letter sent before.

Carl Jeffery: And then we can go through the different MCOs, have them maybe go through their… do you guys want to speak to your numbers?

Jeannine Murray: Well, I realize that we need to look at that Wisconsin person and I meant to do that before I had talked about that on the last quarter; I forgot to look that up. We're thinking that that's an NPI which is the wrong address, but I looked at this data so long ago I can't think of what might have been outstanding at the time to look at it.

Ryan Bitton: I don't have anything on the HPN data.

Holly Long: I can't remember if we already talked about this. Have any of you ever sent letters out like we did? Notifying providers that they were in the top prescribing list?

Jeannine Murray: I don't think that we do send anything out like that that you're kind of a high flyer. The only thing that I can that we send out is more a letter about if it's their member, if it's a member and they're prescribing for a member is a high utilizer, but nothing focused on the physician's prescribing habits.

Ryan Bitton: We have run reports and we've tried to look at, okay yeah, you're our top utilizers but are these people writing more scripts than the partners in the same type of pain management or dental. The data is not perfect because it's hard to get prescriber specialty. So, we don't send out letters like that. We are trying to get better reports to identify those.

Carl Jeffery: Yeah, I think that was the emphasis of our letters, too, that we realize every practice is different and maybe you're completely appropriate, but we just wanted to let you know like where you are compared to your peers, so I think it's a constructive letter I think.

Thomas Beranek: We're not sending them to physicians, but we are sending mail to the patients. As a matter of fact, I finished a report yesterday. We're kind of right now, we're focusing on the Trifecta that we mentioned earlier and if the patient is getting one of those three classes of medications and getting it from two or more doctors, we're about ready to send both the patient and the physician a letter letting them, hey physician did you know, the patient is also getting this from the other doctor and then we wanted to let the patient know, pick one doctor and…

Paul Oesterman: I would be highly surprised if the prescribers were not aware since the requirement is per AB474 was that they look at the PMP before prescribing any controlled substance.

Thomas Beranek: I'm not going to argue but I'm, there's, I mean, from what little data we have compared to the other two MCO's, we're seeing some, I wouldn't say pattern yet because I just combined over the last three months, so our population is finally getting big enough now to where some of that actually looks like it might mean something. We've got a few numbers that keep going up, but everything was going up, so it didn't mean anything. We have a few members that look suspect to me.

Holly Long: Do your letters that each of you send refer to lock in or is that outside of a lock-in?

Thomas Beranek: Outside lock-in.

Paul Oesterman: I can't tell you what to do, but I think we've got very good feedback from the letters that went out and highly recommend similar be done. It's an educational opportunity.

Holly Long: Maybe looking at the top 10 or whatever number you decide on for over a period of time, if they're the top 10 prescribes for over a year, besides Ryan what you're doing to better those reports. That might be a good indication that some additional information or a letter can be sent out, and I'm happy to provide you the language that we used if you want to use that as a template, you can.

James Marx: I guess I'm a little bit concerned just about the focus on numbers and to tell you that we are constantly being contacted about patients to be tapered or reduced. We actually had a patient transferred to us from another pain practice who has a case of hypophosphatemia. There are eight other cases in the United States, but the bottom line is what this condition, you could walk down the street and start breaking bones because you don't have normal bone strength and they just break. He's not even on a high dose, what I would consider high dose, his pain management physician reduced him. We have other cases where patients are being reduced, what I would consider not even particularly high doses and seem to have fairly legitimate situations and we can't really take any more patients right now; we're just overblown because of overhead associated with providing care to these patients. As an unintended consequence, I think a lot of these patients will be diverted. You won't be paying for it; society will be paying for it because a lot of the patients will go up the street and will overdose and we will continue to see an increase in opioid overdoses.

Paul Oesterman: Any additional comments on our opioid concerns, utilizations?

d. Asthma and short-acting rescue inhaler utilization.

Carl Jeffery: For fee for service information, here's the first one. I first started by running a report of all the utilization for the past year of all the different short-acting albuterol products so you can see Proventil is our preferred agent, if it's not obvious and you can see the month over month. Then on the following page, I took a look at the other medications that are being used for maintenance and the other pretty low utilization of those medications. I think what it's telling is the next report after that. The members without maintenance medication/maintenance treatment so these are the members who had received albuterol more than once and who are not on any kind of long-term therapy. They're not really getting appropriate long-term maintenance therapy, so I randomized them into the top 17 on the page but I think there are more than this but I just picked the top numbers.

Paul Oesterman: It might be a good opportunity as a reminder for all of our practitioners to think about prevention, rescue inhaler use versus prevention inhalers and maybe a letter should go out?

Carl Jeffery: Yeah, and this is an ongoing RetroDUR activity, too, that we just watch these. I don't know if there's the…

Jeannine Murray: Like Carl said, we all see the different RetroDUR programs in aligned with the HEDIS measurement. We do have about 30% of the members that use rescue inhalers receive more than one inhaler per month, so they go in for the refill. If it was difficult for me, inhaled maintenance therapy, it looks like about 25% can actually get an inhaler that is maintenance

therapy or preventative, but there's 30%, they get Montelukast but I don't know how many of those really are for asthma versus allergies. It's hard for me to assess those.

Paul Oesterman: Silver Summit? Do we have info from them?

Ryan Bitton: Looking at May, you can see how many members got one or more than one script. Maintenance therapy take the total number of 5200 of total count members, albuterol, I did not look up maintenance specifically.

Paul Oesterman: That's pretty good actually. Pretty high ratio of maintenance.

Holly Long: Do you have prior authorization criteria for this? Is that what you said?

Ryan Bitton: No.

Holly Long: No, okay.

Carl Jeffery: These are the quantity limits right on albuterol?

Ryan Bitton: Yeah. On albuterol.

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

No public comment.

**8. Standard DUR Reports**

a. Review of Prescribing/Program Trends.

**Top 10 Therapeutic Classes for Q3 2017, Q4 2017 and Q1 2018 (by Payment and by Claims).**

Carl Jeffery: Nothing really remarkable. Same old kind of trends and we still see the number one as far as dollars goes is always our hemophilia medications, so they're always ranked up there, when we rank it by pharmacy paid. When look at the number of claims. The opioid claims are really decreasing which promising. We will see what Dr. Marx kind of eludes, there may be some unintended consequences with these but there are 10,000 fewer claims over the quarter in 2018 versus the third quarter 2017 so we're seeing a lot fewer. It's broken down by more specific drug classes and hemophilia medications are still one of our most costly classes of medications to cover.

Jeannine Murray: For Anthem, we don't really notice too many changes. We did review these statistics in the quality meetings every other month so there's really nothing that changing this as far as health and drug classes. Your comment about the opioid, that's one thing when I look at the drug-specific data, saw hydrocodone sitting I think ranked 19 but in our monthly meeting, it's finally fallen out of the top 25 so we don't have an opioid anymore on our top 25 for utilizations. We get excited about that.

Ryan Bitton: I don't' really have any specific commentary.

Thomas Beranek: Ours had held steady since the last meeting. I don't have a good example of changes with opioids, not good or bad.

**Top 50 Drugs of Q3 2017, Q4 2017 and Q1 2018 (by Payment and by Claims).**

Carl Jeffery: Top 50 is on there, too. Again, similar results to previous quarters. I don't think there's too much to remark on those.

Paul Oesterman: Looks like we've got pretty good usage of diabetic test strips and basal insulin.

b. Concurrent Drug Utilization Review (ProDUR)

Carl Jeffery: I don't have anything in there to say what we're working on as far as sending letters out with hep-C treatments and with the asthma medication and then starting to look at psychotropic usage again and see if there is some kind of letter we need to generate with those, but right now our still initial discovery phase of that.

Paul Oesterman: Is there anything the Board wants to request for the meeting next time?

Dave England: Not that I can think of, I think we have it pretty well covered.

i. Review of Q1 2018.
ii. Review of Top Encounters by Problem Type.

c. Retrospective Drug Utilization Review (RetroDUR)

i. Status of previous quarter.
ii. Status of current quarter.
iii. Review and discussion of responses.

**9. Closing Discussion**

a. Public comments on any subject.

b. Date and location of the next meeting.

i. Discussion of the time of the next meeting.

Paul Oesterman: Our next meeting will be October 18, 2018, it was moved up to avoid conflict with Nevada Day. Thank you everyone.

c. Adjournment.

Meeting adjourned at 8:13 PM