MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, December 4, 2024
1:00 p.m. to 4:00 p.m.
Virtual meeting via Zoom

DUR Board Members Present:
Jake Olson, PharmD
Paul Cesarz, RPh
Jeff Huebner, MD
Robert Factor, MD
Jordan Wulz, PharmD

Absent:
Michael Ochowski, RPh
Brook Passolt, MD
Ward Brown, MD

Gainwell Staff Present:
Tom Olson, PharmD
Ashley Beaderstadt
Chally Clegg
Willie Wilberg, PharmD
Katie Counts, PharmD
LaToya Lang
Josh Wampler, PharmD
Travis Copeland, MD

DHS Staff Present:
Kim Wohler
Lynn Radmer, RPh
Tiffany Reilly
Darla Stachowiak
Russell Dunkel, DDS
Susan Seibert
Andrea Hines
Nicole Schneider

Welcome and Introductions
Kim Wohler called the meeting to order at 1:03 p.m. and began with a welcome and thanks to the Board members for their attendance at the meeting. As the meeting was held virtually, Kim provided technical instruction on how the meeting would proceed. A quorum of members attended the meeting.

Review of the Agenda and Board Materials and Approval of September 2024 Meeting Minutes
The members were reminded of the meeting materials sent via email for reference and review. Prior to this meeting, Board members received the agenda, minutes, and RDUR Quarterly Report via email and had the opportunity to review each document. The September minutes were briefly reviewed and approved with an initial motion from **Jeff Huebner** and a second from **Jake Olson**. The motion passed unanimously.

Quarterly DUR Reports
Lynn began by reviewing member enrollment. The enrolled member count does continue to be higher than in the past but continues to decrease due to the end of the public health emergency. Overall decrease of about 324,000 members since Q1 2023, our highest enrollment point. Lynn pointed out that claim volume has started trending downward after leveling off for several quarters. Board members were interested in whether the members leaving the program were uninsured or changed to other coverage. Lynn noted that the DUR core group does not have this information but will try to look at this. A link was provided by Dr. Huebner that may provide some related information. Lynn then reviewed the quarterly reports with the Board beginning with the multiple drug classes report. Lynn reminded the Board that this report identifies members who have claims for all five drug classes (opioids, stimulants, benzodiazepines, sedative hypnotics, and opioid dependence medications) that are tracked for use. Members that are receiving drugs from all five classes are reviewed by a pharmacist for possible inclusion in the Lock-In program or sending physician alert letters. There was one member identified in the last quarter, and that member received a warning letter.

Lynn then presented graphs for the percentage of adults and children on stimulant medications. The percentage of children on stimulant medications remains cyclical due to the school year in this age group, but that trend has become less obvious in the data over time. There has been a sustained increase in use since 2020 in both children and adults, but recently there has been a slight decrease in both children and adults thought to be due to enrollment changes. A comparison graph of children and adults within the total Medicaid population shows that the greatest increase of members receiving stimulants has been within the adult population. The percentage of adults receiving stimulants continues to increase, however, there has been a sharp decrease in the adult population which is likely due to changes in enrollment status. Additional DUR alert trend graphs were presented. Lynn noted that most of the alerts are stable. There has been a slight upward trend in the patient age alert that may possibly be due to the seasonal use of cough/cold products. This is the lowest volume alert. Additionally, the drug/pregnancy alert has been increasing over the last year. A trend graph for high cumulative dose was also presented. Lynn discussed the high cumulative dose alert, and the changes associated to the October 2021 implementation of a soft alert in place of the informational alert. Pharmacists are required to respond to the soft alert and alert trends have shifted because of this change. Lynn noted that the percentage

of overrides has remained stable.

Next, an overview of claim volume was presented to the Board and the percentage of claims with a DUR alert per quarter has continued to remain stable overall and approximately 50% of paid claims are paid with no DUR alerts. She also noted that less than 1% of paid claims have multiple DUR alerts. Slides were presented to review claim count changes. Claim volume continues to decrease. The claim volume from Q3 2023 to Q3 2024 has decreased about 500,000 claims Lynn noted that the changing member population and policy changes could be a component of the decreasing claims volume. Trend graphs for average morphine milligram equivalents (MMEs) per member per day and members utilizing buprenorphine from 2021 - 2024 were also included. The average MME remains stable and has hovered around 41MME for about a year and continues to remain stable. Upon presenting the members on buprenorphine graph it was noted that historically, as the overall average MME has decreased, the overall use of buprenorphine has increased. However there has been a slight decrease in the number of members on buprenorphine over the last four quarters. While this may be a result of enrollment changes, the trend was further investigated to reveal that when looking at the percentage of members on buprenorphine, there is still an increase in use over time.

Two graphs were presented to the Board looking at naloxone member trends from 2021-2024. Naloxone usage has continued to be steady with a slight decrease during the most recent quarter. Further analysis of the trend graph was done based on opioid use and MME levels. This analysis continues to reveal that most members with a claim for naloxone either had no opioid claims or claims for low MME values (less than or equal to 50 MME per day). A second graph with data on the use of naloxone in non-opioid use members revealed the majority of these members are on buprenorphine though the percentage has changed from 70% to 52% over the last several quarters. Lynn presented a slide which was introduced at the December 2022 meeting, tracking naloxone fills for members at 90 MME or greater. From Q4 2021 to Q3 2024, we saw a reduction in members with 90 MME as well as an increase in naloxone dispensed, followed by a recent slight decrease, in naloxone dispensed. The average percentage of members with 90 MME or greater and receiving a naloxone fill in Q3 2024 was 12%, with the average fill rate being 11%. Additionally, a second slide was presented tracking naloxone fills for members receiving buprenorphine for opioid use disorder (OUD). From Q4 2021 to Q3 2024, we saw an increase, followed by a recent slight decrease, in members with OUD as well as in naloxone dispensed. The average percentage of members with OUD and receiving a naloxone fill in Q3 2024 was 8%, with the average fill rate being 10%. It was noted that the slight drop in members and naloxone fills may be a result of the enrollment changes.

Opioid Script Limit

Lynn began by presenting the average MME by override graph. There was a decrease in the average MME by override over the last quarter that brought the average back down to where it had been for the last year. The increase noted last in Q2 2024 was a result of two members on higher MMEs, one due to cancer pain and the second member due to a series injury. The second member was referred to Acentra to review for possible lock-in, but the member does not meet lock-in criteria. There is a process in place to review high MME outlier claims. The top five claims are reviewed each quarter for possible intervention. The percent of override trend was also presented, and overrides are consistently issued for less than 0.5% of the total opioid claims. While the opioid script limit policy impacts a very small number of claims, trends indicated it is an effective policy.

Multiple CNS Depressants

Lynn began by reminding the Board that this is a quarterly intervention. The current methodology for inclusion has been in place since Q1 2022. The methodology identifies members who are concurrently receiving at least one medication from each of the following drug classes: benzodiazepines, opioids (non-MAT), sedative hypnotics, and skeletal muscle relaxants, and are receiving 45 or more actual days' supply of each of the four medications during the quarter. The member must have a claim for each drug class in the last month of the quarter. The selected members are reviewed, and a letter is sent to prescribers regarding the risks of the noted polypharmacy. Letters are sent quarterly to providers of newly identified members and annually to prescribers of previously identified members. A full refresh of all identified members is done in the second quarter each year. For Q3 2024, there were 176 members on all four drugs, 75 members with 45 or more total days' supply, and 18 members were selected for intervention. Lynn reminded the Board that all of these numbers can be located and will be updated quarterly on the continuing intervention spreadsheet.

Continuing Interventions

Lynn closed out the Updates and Quarterly Reports with a review of the Continuing Intervention spreadsheet. She reminded the Board that the retrospective high MME intervention was changed in October 2024 to identify members on

120 MME or more per day. This was a decrease from 150 MME per day. The volume of members identified continues to be larger, as expected. She also reminded the Board that the Opioid/Benzodiazepine intervention is an ongoing quarterly intervention. There are two phases to this intervention. The phase one letters are focused on members who have chronic opioid (non-medication-assisted treatment), and benzodiazepine use and who are at 50 MMEs or greater per day. Chronic use is defined as 90 days each of opioids and benzodiazepines in 90 days. The phase two letters involve members who have chronic opioid (non-medication-assisted treatment), and benzodiazepine use and who are at 50MMEs or greater per day, but phase two specifically identifies the top prescribers with members meeting the criteria and who previously received the phase one letter. She noted that next quarter all prescribers identified in phase two will receive letters. Lastly, Lynn discussed the two types of monthly Sickle Cell disease interventions and noted that Oxbryta, a disease modifying drug for Sickle Cell disease, was withdrawn from the market. These interventions identify members with underutilization of disease modifiers and overutilization of opioids with concurrent underutilization of disease modifiers. She noted that, as expected, the volume of letters is small. The data for all of these interventions is available on the Continuing Interventions spreadsheet.

Underutilization Discussion

Katie began the discussion by reminding the Board of the prospective DUR late refill alert presentation at the June 2024 meeting. She noted that based on the top drugs identified via the DUR late refill alert, Acentra performed a focused underutilization intervention in July 2024 for the following medications: citalopram, escitalopram, fluoxetine, sertraline, duloxetine, vilazodone, vortioxetine. An additional subset of antidepressants was identified by the DUR core team for intervention in September 2024 (bupropion, paroxetine, venlafaxine, and desvenlafaxine). Katie went on to give an overview of the criteria parameters used to identify a member for an underutilization letter for the antidepressants followed by the volume of members identified for review, the number of members reviewed, and the number of members selected for intervention. It was noted that this group of antidepressants seemed to have more use for non-psychiatric indications as well as possible off-label use than the first group of antidepressants. Rationale as to why a member may not have been selected for intervention was discussed, including fill dates and dose or medication changes. She also indicated that the full group from July and September will be reviewed in January 2025 and analyzed for presentation to the Board later in 2025.

Also, as a result of Board discussion at the September meeting, additional asthma controller medication reviews were performed. The selection of medications included in these interventions was based on the preferred products on the PDL. Katie went on to give an overview of the criteria parameters used to identify a member for an underutilization letter for the asthma controllers. These parameters included limiting member selection to those with a diagnosis of asthma. She also shared the volume of members identified for review, the number of members reviewed, and the number of members selected for intervention. Rationale as to why a member may not have been selected for intervention was discussed, including fill dates and dose or medication changes. Additional rationale specific to the use of the products included differences in refills schedules based on patient age and clinical consideration for possible appropriate “as needed” use based on published guidelines.

Quantity Limits of Short-Acting Opioids Discussion

Lynn began the discussion by reminding the Board that a change to the short-acting opioid quantity limit was discussed at the September 2024 meeting. She reviewed with the Board the medications included in the edit and functionality of the edit. The current cumulative quantity limit is 360 units in a rolling month time frame. The new cumulative quantity limit for short-acting opioids will be 240 units in a rolling month time frame. The change will be implemented March 1, 2025. Based on Board discussion at the previous meeting, there will be a transition period from March 1st to March 31st. During this time, prescribers can request a one-time quantity limit override while adjusting member medications regimens. Lynn also reminded the Board that after the transition period the quantity limit can be overridden in certain situations by the DAPO call center. The length of the override may vary depending on clinical considerations.

Demographics Review of ADHD in Children

Lynn began the discussion by sharing with the Board that in October 2024, CMS released some data around stimulant use in children based on parent responses to a 2021-2022 National Survey on Children’s Health. The survey identified children 3-17 years of age with a diagnosis of ADHD. The data compared children with public coverage and private coverage based on diagnosis and percentage of children on ADHD medication. Data was also stratified by gender and age group. The CMS data indicated that children with public healthcare coverage had a higher incidence of an ADHD diagnosis (13% vs. 9%). Within public coverage, males had a higher incidence of an ADHD diagnosis. There was no significant difference in the

percentage of children receiving medication for ADHD in public and private coverage (57% vs. 55%). She indicated the DUR core team thought it would be interesting to also provide Wisconsin Medicaid data for the Board review. While there was no way to replicate the study, pharmacy claims data and diagnosis data were utilized to obtain stratified data for a similar time period. Lynn presented several slides with Wisconsin Medicaid data from Federal Fiscal Year (FFY) 2022 and 2024. The data for the two years is very similar, with the numbers from 2024 being slightly higher. Lynn closed the discussion reminding the Board that Wisconsin has several initiatives involving stimulant use that Dr. Copeland will be presenting.

Children's Mental Health Program Stimulants Initiatives

Dr. Copeland started this discussion by reminding the Board that the current stimulant initiatives consist of three parts: quantity limits for stimulant prescriptions, prior authorization requirements for selected stimulants, and member case reviews. There are three scenarios that are identified for a member case review: any child under the age of four being started on a stimulant, any member of any age utilizing methamphetamine as their stimulant medication, and children receiving high dose prescriptions. The Board was reminded of the drugs requiring prior authorization. Dr. Copeland went on to further discuss the dose monitoring, screening, and case review process. Dosing patterns are reviewed for each stimulant on a quarterly basis to identify outlier prescription patterns and members on high dose stimulants. He shared the clinical thresholds for identifying high dose prescription outliers. High dose thresholds are determined based on safety data, FDA initial approval dosages, and common doses utilized in clinical practice. It was noted that the high dose threshold for methylphenidate is, at times, more difficult to discuss due to a recent meta-analysis concluding that there is lack of data to support the limitation of methylphenidate doses. Dr. Copeland indicated that another recent meta-analysis (October 2023) around amphetamine/dextroamphetamine doses has been published that found small to no benefit from doses higher than FDA indications with increased adverse events and this was used to make a downward adjustment to the high dose threshold for amphetamines. He also reminded the Board that the polypharmacy methodology was added in 2023 to aid in identification of members on multiple stimulants who may also be considered as high dose and need further intervention. Slides were then presented that depicted the utilization patterns of drugs by member count from Q1 2015 thru Q3 2024, and members with a dose per day over the dose thresholds by drug for the same time period. Dr. Copeland went on to share slides for each drug to indicate the current number of children that exceed the maximum dose threshold for each drug.

To close out this discussion, Dr. Copeland further discussed the polypharmacy methodology utilized to identify members and prescribers for possible prescriber outreach as a case review. He indicated that in 2023 there were five members at greater than 120% of threshold. Currently, there are 11 members at greater than 150% of threshold, 21 members between 120% and 150% of threshold, and 24 members between 110 and 120% of threshold. Some of these numbers are driven by the change in the dose threshold for amphetamines but that is not the only driver noted. There seems to be an increase in higher dosing patterns for other medications also contributing to these numbers. Of the 11 members in the top group, four of the providers had been previously contacted in 2023. These cases are still being followed and Dr. Copeland indicated that these providers stated they are implementing more monitoring and more frequent appointments. A second group of previous providers was noted to have fewer members in the top ten members. The new providers identified for outreach were primarily in psychiatry and indicated they were more comfortable with higher doses being used over time. Conversations with these providers focused on monitoring safety parameters and communicating limitations to increasing dose for symptom improvement. He went on to indicate that the two goals for these interventions are to reduce doses or prescribing (where appropriate) and to increase side effect awareness to reduce morbidity. In order to reach these goals, the quarterly reviews will continue with outreach to newly identified providers and ongoing outreach to previously identified providers. It was noted that with the increase in the number of members above the dose threshold, development of a letter to go to all members above 100% of threshold is being considered.

Note: Dr. Copeland discussed the resources that could be made available to the prescribers contacted in our initiatives to assist with our members challenging psychiatric needs. At the last Board meeting, Dr. Brook Passolt inquired about the ability to connect prescribers with the Wisconsin Child Psychiatry Consultation Program (WI CPCP) which is a program providing Child Psychiatry Consultation Services and supported by DHS and the Wisconsin legislature through 2014 ACT 127 and developed with Medical College of Wisconsin. Dr. Copeland reached out to WI CPCP staff to discuss how best to coordinate these connections. Staff with WI clarified that they are at present only able to provide consultation services to primary care providers, but not to psychiatric specialist providers. A relatively small number of members identified in our initiatives have primary prescribing done by primary care providers. Dr. Copeland discussed individually reaching out to appropriate providers in calls and direct contact, but not directing prescribers to the WI CPCP program in letters generated

in our larger mailing-based interventions. The vast majority of providers receiving the letters would not be able to avail themselves of this consultation resource.

Multiple CNS Depressants Impact Analysis

Lynn began by reminding the Board that this topic has been discussed several times previously and that this is an ongoing quarterly intervention. This intervention identifies members who are concurrently receiving at least one medication from each of the following drug classes: benzodiazepines, opioids (non-MAT), sedative hypnotics, and skeletal muscle relaxants. She noted that there have been several iterations of the intervention parameters. Initially, members were identified for inclusion when they had a claim for each drug class at any time during the quarter and had a 90-day supply of each medication in the quarter. As of Q1 2022 the inclusion parameters were updated to identify members when they have a claim for each drug class in the last month of the quarter and have at least a 45-day supply of each medication in the quarter. The current parameters were utilized for the impact analysis. Lynn went on to share the impact analysis data for the members identified for letters during Q3 2023. During that quarter 78 members were identified for letters. For the same period a year later (Q3 2024), 66 of those members were still enrolled and eligible for analysis. It was determined that 39 members still meet criteria for intervention. The intervention had a 41% success rate. She then discussed that while the intervention identifies a small number of members, it is successful and will be continued on a quarterly basis. Letters are sent to prescribers of newly identified members quarterly with a yearly reset with letters sent to prescribers of all members (new and repeat) in July.

Polypharmacy of Sedating Medications in Children Impact Analysis

Lynn began by reminding the Board that this topic has been discussed by Dr. Copeland several times, most recently at the September 2024 meeting. This intervention identifies children who are concurrently receiving medications from at least three of the sedating medication drug groups. She noted that there have been several iterations of the intervention parameters, including changes to the drug groups and days' supply used for member identification. The parameters utilized for this impact analysis are members who have at least 90 days of medication in the last quarter for at least three of the following drug groups: sedative hypnotics, benzodiazepines, antipsychotics, melatonin, antidepressants, antihistamines, and clonidine (immediate release). Lynn went on to share the impact analysis data for the members identified for letters during Q2 2023. During that quarter 310 members were identified for letters. For the same period a year later (Q2 2024), 301 of those members were still enrolled and eligible for analysis. It was determined that 152 members still meet criteria for intervention. The intervention had a 49.5% success rate. She then discussed that the identification parameters have been updated to facilitate a scheduled intervention every six months. The members will be identified by the following parameters: those who have a claim for medications from at least three drug groups in the last month of the quarter and have been on those drugs at least 80% of the time in a 180-day period. The drug groups have not been modified. For the scheduled intervention, prescribers will receive a letter for all new member/prescriber combinations. Member/prescriber combinations receiving letters will be suppressed for one year following the intervention.

PDL Update

Lynn provided a brief PDL update from the November 6, 2024, PDL meeting. Public testimony was given from 22 manufacturer representatives and two clinicians. There were 47 previously reviewed drug classes with no new classes reviewed. The Prior Authorization Committee voted to endorse all staff recommendations, and the DHS secretary has now accepted all recommendations. They are still in the process of publishing update materials for the changes that will be implemented on January 1, 2025. Lynn reminded the Board that at the May meeting there had been significant discussion around the GLP-1 class due to drug shortages. She reminded the Board that Ozempic® was temporarily added as a preferred agent. She indicated that drug shortages have abated and as of December 1, 2024, Ozempic® returned to non-preferred status. There is no PA exemption for this product.

Adjournment

Robert Factor motioned to adjourn the meeting. The meeting adjourned at 3:32 p.m. Upcoming meetings are on the following Wednesdays: March 5, 2025, June 4, 2025, September 10, 2025, and December 3, 2025.

Guests: John Bullard, Alexion; Kimberly Eggert; Gary Parenteau, Dexcom; Robert Robey, Indivior; Akesha Coleman, Johnson & Johnson; Kelly Ruhland, Lilly; Laura Etheridge, SK Life Science; Shannon Meece, Pfizer; Sherry Betthauser, Jazz Pharma; Robyn Bruining, Sanofi; Kellie Murry, Neurelis; Kelly Hamilton, Takeda; Danielle Brolsma, Teva.