

WY P&T Committee Meeting Minutes  
Thursday, February 11, 2021  
Cheyenne, WY via Zoom  
10 a.m – 1 p.m.

Members present: Alissa Aylward, Melinda Carroll, Hoo Fang Choo, Joseph Horam, Paul Johnson, Scott Johnston, Kristen Lovas, Robert Monger, Chris Mosier, Scot Schmidt, Patrick Yost

Excused: Garry Needham

Ex-officio: Cori Cooper, Melissa Hunter, James Bush, Patrick Johnson

Guests: Melissa Eames, Sandra Deaver, Matt Robison (CHC), Nikki Yost (CHC), Misty Helenbolt (CHC), Corwyn Moss (CHC), Doug Wood, Frank Del Real, Alex Bitting, Beth Robitaille, Richard Dabner, Susan Kelly, Aimee Redhair, Rachel McArthur, Jody Legg, Jason Smith, Coleen Fong, Britt Boehner, Lori Howarth, Jan Stall, Jane Stephen, Matthew Wright, Jenna Gianninoto, Joe Ferroli, Deb Guay, Deron Grothe, Kim Walter, Chi Kohlhoff, Vincent Lawler, Rhonda Clark,

Dr. Monger called the meeting to order at 10:00 a.m.

Introductions were made. Aimee made a quick introduction of Misty Helenbolt, Cory Moss and Patrick Johnson, all new employees with the Department of Health and Change Healthcare. Aimee announced that this is Dr. Horam's last meeting as he has hit his 12-year term limit. His input on this Committee has been invaluable and he will be greatly missed. A pediatrician will be sought to fill his position.

Approval of Minutes

The minutes of the November 12, 2020 meeting were approved.

Department of Health

A. Pharmacy Program Manager Report: Cori reported that a lot of time is being spent on the technical side, with coordination of systems. A lot of work has gone into preparing the system for pharmacies to bill for the COVID vaccine, Programming will be implemented 2/16. Pharmacies will be able to back-bill any vaccines administered since 1/1/2021. The vaccine is free. Medicaid is paying for administration only. For uninsured patients, pharmacies can bill an uninsured fund so there is no cost to the patient.

B. Medical Director Report: Dr. Bush reported that a series of reviews with Dr. Behringer have identified patients receiving more than 120 MED per day as well as opioids and benzodiazepines in combination. He provided an overview of a CME program that many states are using for narcotic CME requirements. He is looking for an endorsement from the Boards. He will email the program to Committee members. He requested that we revisit Medicaid limits and consider lowering the MED limits. The topic will be added to the May agenda.

C. DUR Manager Report: Aimee reported that five Committee members claimed CME for the last meeting. The disclosure only needs to be submitted annually.

#### Old Business:

A. As requested, Aimee provided a clinical review of Parkinson's agents. Alissa indicated that when she worked with a neurology clinic, Sinemet was most commonly used, sometimes Amantadine. It was suggested that we reach out to a neurologist for additional feedback.

The Committee noted no evidence of a difference in safety or effectiveness among Parkinson's agents. They requested that we consult with a neurologist on the final policy. There was a motion, second and all were in favor.

#### New Business

##### A. PA Criteria

###### 1. Review existing criteria

i. Suboxone criteria was discussed at the request of Dr. Frank Del Real and Dr. Beth Robitaille. The news release from the Department of Health and Human Services regarding the removal of the prescribing waiver for Suboxone was discussed. It is believed that this has been put on hold for the time being.

Dr. Del Real discussed potential concerns with access to care resulting from the Suboxone prior authorization process. The process can be onerous and time consuming, especially for initiation. Time is of the essence when starting these patients. He requested that we consider streamlining, or not requiring PA for doses under 16 mg. The usual dose for treatment is 8 – 16 mg. There have been questions in the past regarding the reason for using doses above 16 mg since the mu receptor sites are saturated. However, some patients will need higher doses. These patients remain on the same doses for years and never require increases.

It was asked if Medicaid was an outlier in terms of our PA criteria compared to other insurers. Dr. Del Real said that it really depends. Blue Cross Blue Shield does not require PA, but others do. Dr. Robitaille with UW Family Practice has been working with Dr. Del Real for several years after receiving opioid abuse disorder grant funding. She indicates that Medicaid is the most challenging payer.

Cori explained the system limitations and the reason that providers see a PA requirement for every dose change. It is not our desire to micromanage to this level. It is simply the PA system's capability. To stop these PAs we have to remove the PA requirement for all doses under a certain level.

Dr. Del Real also noted that this is a chronic disease and asked that we not require them to taper down after 2 years. When patients need more than 8 mg per day, they either have to pay out of pocket for the additional dosage, or discontinue treatment.

There was a question regarding what triggers relapse. Is it the acute pain management that comes up during their recovery? Dr. Del Real answered that, if they are stable at the 2-year mark, odds of relapse are low. It is the first 16 months of treatment when relapse risk is high. It is often the patient's fear that their pain management needs will be ignored because of their history of opioid use disorder. Dr. Del Real understands that it is not approved for pain, but also feels like it is an excellent pain medication so uses it off-label for that purpose.

It was suggested that we allow the first 30 – 60 days for the dose to be titrated to the appropriate level. After 60 days, a prior authorization should be required for any further dose increase.

The PA Help Desk was asked to provide data regarding the number of PA requests received and how many were ultimately denied. They can compile this information and provide to the Committee for further discussion. It was asked if we should table the discussion until we have this additional data.

It was asked if we could just require a diagnosis of opioid dependence on the prescription. We can do a lookback for any diagnosis in our system. However, there is a time lapse before medical claims enter the system, meaning that PA would still be required for new patients initiating treatment.

Dr. Robitaille mentioned that the regulatory Boards and DEA are monitoring prescribing habits and Medicaid does not need to be doing this through the PA process. Aimee clarified that this is absolutely not our intention. The federal charge of the DUR Program is to ensure appropriate utilization of medications in the Medicaid population. Oftentimes, this can only be done through prior authorization.

Melinda made a motion that the PA requirement be removed for 16 mg and under as she views it as a barrier to access. There was a second for this motion.

Other Committee members indicated that they were uncomfortable making a decision without additional information.

The motion failed with a vote of 5 for and 7 against. Aimee will gather the additional information and disseminate via email so the decision does not have to wait until the May meeting.

ii. Sunosi was last reviewed in August 2019. At that time, there was no comparative data. The Committee determined that there was no evidence of a difference in safety or efficacy for narcolepsy. Additional criteria was created for obstructive sleep apnea. The Department of Health would like to manage the narcolepsy class on the PDL, and needs criteria for approval of a non-preferred. There was a motion,

second and all were in favor of a 3-month trial of modafanil prior to approval of Sunosi for narcolepsy. All were in favor.

## 2. New Drugs

i. Oxlumo is indicated for the treatment of primary hyperoxaluria type 1 to lower oxalate levels in adult and pediatric patients. Alex Bitting (Alnylam) provided public comment. Alnylam was the company that first created the technology that made the COVID mRNA vaccines possible. Oxlumo is approved to treat a rare disease that ultimately leads to renal failure. The average age of diagnosis is 8 years. The prevalence is very low and there are no treatment sites in Wyoming. It is primarily a medical benefit drug though it could be given via a local clinic or pharmacy. There was a question regarding the length of trials. The kidney stone trials take years, though they anticipate long-term data to show a decrease in kidney stone formation, nephrocalcinosis, and end stage renal disease. Chris noted that it might be used in a variety of indications eventually.

There was a motion, second and all were in favor of limiting to indication.

## 3. Determine need for criteria

i. Singulair high dose utilization was reviewed. Aimee contacted providers who were prescribing the high doses. They were very willing to reduce the doses. Dr. Horam noted that he's prescribed Singulair over a long period. He has never seen a reason to go higher than the recommended doses. Dr. Johnson echoed that sentiment. There are many other options. There was a motion, second and all were in favor of limiting to labeled maximum doses. Aimee will reach out to providers with patients currently receiving high doses to alert them of the change. Patients will not be grandfathered.

## 4. Other

There being no further business, the open portion of the meeting adjourned at 11:30 am and the Committee met in closed session.

Respectfully Submitted,

Aimee Lewis  
WYDUR Manager