Raymond Tan (PharmD)- Zenith – Medicare/Medical formularies and group health formularies: at pharmacy, pharmacist has to gather all necessary information. IW will receive quality care that is evidenced-based. Need system infrastructure. Cost effectiveness is flexible. How fast can it be utilized? Formulary can be linked to injured worker. Process should require only one phone call. A formulary reduces pharmacy administrative burden.

Bob Blink, MD (occ med physician) WOEMA – Supportive of well implemented formulary – streamlines, reduces abuse. Implementation is major concern. New prescription needs reasonable process for outliers. If already on medications, patient needs transition process that is robust and carefully managed. Some medications can't be generics and need process for approval. Morphine equivalent dosage reduction – need process. Some patients very vulnerable. Dispensing meds from physician office should be allowed for truly needed meds at least during initial period – hard for patients who have transportation issues. Perhaps a sub-formulary for that purpose. MTUS guidelines – need to make sure all consistent. Physician needs one document to refer to. Will submit comments in writing. Will send in feedback from members.

Ken Eichler – ODG - Other jurisdictions have formularies, and we can learn from them to create smooth process. Re cost analysis, the focus should be on medical appropriateness, not cost except that generics should be used over brand. Injured workers should get access to brand if needed (i.e. allergic reaction to drug). Should be blind to costs and rebates. Emergency room, urgent care– have special niche, not same standards. There should be a limit on length of first fill – 90 days supply on first fill is not good medicine. Overdose issues. Formulary should be tied into other guidelines. Education for all involved – injured workers (IAIABC – formulary hot issue and recognizes education is important) and physicians. Need ease of use. Figure out how it works with UR, RFA, and IMR processes.

Denise Algire - Albertsons and Safeway – Have employees in WA and TX. Formularies streamline administrative burdens. In WA, can have significant range – goes to NDC – for generic cost spread. Seen benefits. Usually, formulary in database for pharmacy. If issue, pharmacist calls physician. Need real time adjudication if issue. There is a disconnect between what pharmacy pays and maximum price on formulary. WA formulary is for all prescribing in state (monopolistic state) except private programs.

Sandy Tucker – Medical Management Services for AIG - licensed pharmacist and attorney in TX. In TX, as of Sept. 2010, closed formulary for new claims and 2013 for existing claims. Includes all FDA approved drugs, except experimental. Those excluded require pre-approval. All on list should be approved and can only do retrospective review. Y drugs have no restrictions. TX has been successful. Oklahoma – also look at compound drugs and if unrelated to WC injury. OK started 2/14. OH and WA monopolistic states. Closed formulary helps change physician prescribing and opioid issues.

Brian Allen - Helios – TX drug formulary. Medications prescribed but not related to injury was an issue. Right drug for right reason. Y and N matrix. N is discouraged but can still get. Formulary based on guidelines, but need to use common sense beyond formulary. Helps communication. Almost immediate compliance with formulary. Good education re purpose and goals. Can file for an order if problem.

Only 18 filed in first month. 10-15 issues per month re injured workers not getting drug at pharmacy (could be N drug). Don't see access for care issues in TX. PBMs can work with formulary to make sure injured workers get drugs needed.

Denise Algire - Albertsons and Safeway – Benefit eligibility file provided to pharmacy to help address issue where drugs not related for injury. Most PBMs have process for 3 day fill until eligibility is established.

Sandy Shtab - HealthESystems PBM – If claim eligibility file hasn't been received by PBM, pharmacy will accept for first fill (3 – 7 days) – even if eligibility not established, carrier needs to reserve right to do review for injuries not related to claim. Formulary and MTUS only speak to medical necessity. Carriers and PBMs need to work together to customize formulary for specific populations. If have PBM, can work with formulary and pharmacy and MPN. Employees receive notification re how to access drugs via MPN pharmacy.

First fills – Pharmacies often have third party billers to assume risk of providing drugs that may be denied.

Joe Carresi - Southern California Edison – SCE provides employees with form so they can get drugs immediately as a first fill.

Bob Blink, MD - WOEMA – process must work well for all injured workers, not just most. Re physician dispensing, Bus and Prof Code – "dispensed" includes handing prescription to injured worker. Cf subdivisions (a) and (b).

Steve Cattolica - CSIMMS – How will delivery system change?

Deb Kuehn - US Healthworks – Clinics in 20 states. Set up formularies in different states.

Lucy Shannon- Regroup and ACOEM – Formularies new to WC. Can related drugs to injury, episode of care. Not all formularies do this but CA could.

Melissa Cortez – Want most appropriate medication for IW injury. Based on evid base WC specific source – look at other states. ODG and ACOEM. Don't interfere with existing med management and MTUS – tie together. In TX, education program very helpful so worked on day one. Physicians, pharmacists. 2 phased implementation, esp for IWs who need to be weaned. Will submit written comments.

Martin Brady - Schools and Insurance Authority - In favor of formulary. Prescription drugs are bought and sold on school campuses, phishing parties with drugs in bowls. Need to address these issues.

Does formulary match diagnosis? Most relate to category of diagnosis.

Denise Algire - Albertsons and Safeway - Just because drug is on formulary doesn't mean it applies to any injury/condition, must tie into MTUS. Each state had requirements. Pharmacist should verify what drugs injured worker already taking, but don't all share same info.

Jay Garrard – GSG Associates - Medications contraindicated with other medications patient is taking must also be taken into consideration.

Sandy Shtab - HealthESystems PBM - Physician should note what medications injured worker on when prescribing, but pharmacy should also come into play.

CURES system? Status – DOJ. The MTUS recommends physicians use it.

Denise Algire - Albertsons and Safeway – CURES was updated in 2/15 – a little more user friendly. Also there is a national data base. 24 states have signed on, but not CA. CURES allows pharmacists and physicians to access CURES to check for controlled substances. Lag time? DNK. From date filled not when prescription written.

Raymond Tan - Zenith – as of 1/16, every pharmacist has access, but not required to use CURES. Is available, pharmacists say it works.

Lisa Anne Forsythe - Coventry – PBMs and MPNs should be able to keep control if directed to first fill.

Tom McCauley – NBD -Can't solve all issues – delivery, coverage, off-label, billing with formulary. Evidenced based medicine – many pharmaceutical studies go unpublished.

Dinesh Govindarao, MD - St. Fund – TX allows for retrospective review. Has TX thought about going to prospective review for Y drugs?

Brian Allen - Helios - TX is making changes. Compounds became an issue. Collecting data on compounds before acting. Talking about stakeholders re unrelated drugs. Expects some resolution re that issues.

OK doesn't have accepted approval for Y drugs.

Dinesh Govindarao, MD - St. Fund - First fill for acute is important, but also need some protections from abuse.

Bob Blink, MD – WOEMA - Office dispensing should be narrow. Retrospective review re Y drugs: acceptance of injury, body part, appropriateness for injury, should give up right to challenge appropriateness. Mandatory review of compounds.

Greg Johnson - WCIRB – if anything not FDA approved – doesn't that prevent compounds? Still up in the air in TX.