Center for Operations and Pharmacy Management
Drug Utilization Review (DUR) Board Meeting Minutes
Wednesday April 8, 2009
Electronic Data Systems Conference Room
171 Service Avenue
Cranston, Rhode Island

DUR Board Members Present:	Tara Higgins, RPh, CGP, CDOE Stephen Kogut, PhD, RPh, MBA Ray Maxim, MD Richard Wagner, MD
DUR Board Members Absent:	Ellen Mauro, RN, MPH John Zevzavadjian, RPh
Others Present:	Paula Avarista, RPh, MBA (RI Medical Assistance Program) Ann Bennett (Electronic Data Systems) Karen Mariano (Electronic Data Systems) Joe Paradis, PharmD (Health Information Designs)

There were no changes made to the minutes from the December 3, 2008 meeting.

Paula Avarista summarized recommendations that were made at the Pharmacy and Therapeutics (P&T) Committee meeting held yesterday on April 7, 2009. One of the recommendations was to make short acting insulin pens available as preferred agents. Currently only vials are preferred. The utilization of pens will be monitored to determine if their use increases after they are made preferred.

There was some brief discussion regarding duplicate therapy with antipsychotic agents. Board members indicated that there are cases where two agents are justified, such as the use of clozapine and another agent or the use of rescue oral medications for patents using long acting injectable antipsychotic agents. It was also noted that Medicare is considering adding a quality measure for Part D plans that would evaluate the use of duplicate antipsychotic therapy. This topic will be discussed in more detailed later in the meeting.

At the December 2008 P&T Committee meeting, the Committee recommended that the DUR Board review several specific drug utilization issues. They included the following

- Doses of Vyvanse® greater than 70mg per day.
- Use of Cymbalta® for off-label uses. The drug is indicated for depression, fibromyalgia and neuropathy.
- Evaluate poor adherence to combination statin products and combination ACE Inhibitors, ARBs and Calcium Channel Blockers.
- Evaluate duplicate therapy of long acting stimulants.
- Use of newer anticonvulsant agents for non labeled mental health diagnosis.

For the calendar year of 2008 and the first two months of 2009, only one patient was found to be taking a dose of Vyvanse® greater than 70mg. However, the patient recently discontinued the drug and is now taking Adderall® XR.

Approximately one quarter of the patients with claims for Cymbalta® did not have a diagnosis that is listed in the product labeling. However, the drug is indicated for fibromyalgia and no specific ICD-9 code is available for this particular diagnosis. Since the drug is non-preferred and requires prior authorization, requests for the drug could be reviewed to determine what diagnoses appear on the request forms.

Specifically the P&T Committee had requested that the DUR Board evaluate non-compliance of ACE inhibitor, ARB and statin combination products. Currently, HID does not have criteria in place to review underuse of these combination products. However, criteria will be developed. The utilization of these products is also low compared to the overall use of statin, ACE inhibitors and ARBs. HID does have in criteria for the ACE inhibitors, ARBs and statins. Underuse criteria for statins are active for Rhode Island. Underuse criteria for ACE inhibitors and ARBs will be activated. Currently criteria are set to alert if less than 78% of drug dispensed, based on days supply, has been utilized. The exact criteria is set at less than 70 utilized units over the most recent 90-day time period.

In evaluating underuse criteria for statins, approximately 10% of patients with any claims for statins over the previous three months had exceptions to the criteria. However, the Board noted that looking at data for all of 2008 showed that patients on average had only five refills per year of statins, suggesting poor adherence overall. It was also noted that all patients' data are included and continuous eligibility of patients was not determined. In addition, it is likely that what appears as gaps in adherence for some patients may be due to hospitalizations. It was recommended to compare adherence rates for Rhode Medicaid with other state Medicaid program or other health plans if possible. The Board also recommended that criteria be developed to evaluate poor adherence to metformin.

The Board indicated that poor adherence is an ongoing issue for almost all patient groups for asymptomatic conditions such as hypertension and hypercholesterolemia. The longer patients are taking medications, the lower their adherence rates. The link between low adherence rates and increasing hospitalization rates was noted. A program initiated by Blue Cross to improve adherence was discussed which involves patients being assigned a "health coach" to help improve adherence rates.

Specific to poor adherence to lipid lowering medications, Board members suggested that laboratory data be used to determine if patient cholesterol levels were controlled. Lab data for Medicaid patients is not available for review. However, procedure codes could be reviewed to determine if labs were at least being performed on a regular basis. It was noted by Board members that for monitoring patients with diabetes there are specific procedure codes (CPT-II codes) for Hemoglobin A1c than indicate if the level is greater than 9.0%, between 7.0% -9.0% or less than 7.0%. Review of these codes for specific patients would indicate if patients with diabetes were controlled over time without the need to review actual laboratory data.

Only five patients were noted to be taking two different long acting stimulants concurrently. The Board asked if the total number of patients taking long acting stimulants could be determined to calculate the percentage of patients on two different agents.

The use of some of the newer anticonvulsants was evaluated. Based on the broad range of diagnoses noted for patients taking these agents, it is very difficult to determine if the agents are being used extensively for off label uses. The possibility of implementing step therapy for some of the agents was discussed. It was noted that some off label uses of these agents are noted in currently accepted treatment guidelines. It was also noted that some of these agents have just been made available generically such as tompiramate (Topamax®), divalproex (Depakote®) lamotrigine (Lamictal®), evetiracetam (Keppra®) and oxcarbazepine (Trileptal®). The utilization of these agents will continue to be monitored.

Paula Avarista briefly described the new waiver program to take effect July 1 2009. This program would mandate managed care for virtually all patients, with the exception of Connect Care Choice patients who would remain fee-for-service. This will dramatically reduce the size of the fee-for-service Medicaid population. Other claims that are processed fee-for-service are claims for dual eligible patients for drugs not covered under Medicare Part D and RIte Share claims where Medical Assistance pays for the copayment.

In light of the fact that the fee-for-service population will be smaller after July 1, 2009, Board members suggested that the DUR Board be expanded to include representatives from other health plans. The DUR Board is a federally mandated Board which is responsible for monitoring drug utilization for fee-for-service Medicaid patients.

The use of duplicate antipsychotic agents was discussed. A comparison of the rates of duplicate atypical antipsychotic therapy was performed for the following four state Medicaid programs; Rhode Island, Maryland, Connecticut and West Virginia. Rhode Island had the highest rate of duplicate therapy among the four states. A letter was sent to the Medical Directors of the Community Mental Health Centers along with a copy of the findings. The Board requests that the prescribers of duplicate therapy be identified and if possible determine how many were psychiatrists or primary care providers. Other health plans such as Blue Cross and Optima have also reviewed the use of multiple antipsychotic agents.

Detailed data of the duplicate agents was presented to the Board and the Board requests if the data could be summarized to determine which agents were used most frequently as duplicate therapy. In some cases duplicate therapy may be justified, as with the case of using a second agent to augment clozapine or the use of oral rescue agents along with long acting injectables. There is concern with the use of low dose quetiapine as an added agents used solely for its sedative properties. Cost saving goals set for the PDL based on the addition of the atypical antipsychotics may not be met if the use of unjustified duplicate therapy increases. Dose optimization of the atypical agents was also discussed.

The use of methadone and Suboxone® was discussed. It was noted that a small number of patients were found to have claims for narcotics while taking Suboxone®. This will continue to be monitored. The Board recommended that drug-drug interaction criteria be developed to evaluate the use of methadone and antipsychotic agents that may lead to prolonged QT intervals.

A summary of DUR profiles reviewed, letters mailed and responses for 2008 was distributed to the Board.

The next meeting is scheduled for Wednesday June 3, 2009 at 8:00am.