Executive Office of Health and Human Services

RI Department of Human Services

Drug Utilization Review (DUR) Board Meeting Minutes

Date - Tuesday, April 16, 2013

Meeting - 10:30 AM

DUR Board Members Present:	Michelle Booth, RPh Stephen Kogut, PhD, RPh, MBA Ellen Mauro, RN, MPH Richard Wagner, MD
DUR Board Members Absent:	Linda Rowe Varone RPh
Others Present:	Ann Bennett (HP Enterprise Services) Karen Mariano RPh (HP Enterprise Services) Kathy Novak (Magellan) Joe Paradis, PharmD (Health Information Designs - HID)

Minutes from the December 11, 2012 meeting were approved with minor changes.

HP noted that a search is underway for a physician candidate to serve on the DUR Board. There was also discussion regarding what role the Medicaid Medical Director would play with respect to the DUR Board.

There was discussion regarding the Connect Care Choice (CCC) lock-in program. Patients are referred to being restricted to a single pharmacy due to the overuse of emergency room services. Patients are assigned to a primary care provider but cannot be restricted to a single prescriber. Therefore, the only action that can be taken is to restrict patients to a single pharmacy. The Board asked if ER physicians were aware of the lock-in status of the CCC patients. ER providers do not have a means to determine if a patient is restricted to a single pharmacy. HID noted that 58 recipients were locked-in for the CCC program based on data from January 2013. HID was not aware that these patients were restricted to a single pharmacy. However, through the lock-in screening process, HID sent DUR lock-in alert letters to prescribers for 21 of these patients during 2012. Of those 21 alert letters, 4 were sent after the patients were already restricted to a single pharmacy. A listing of patients in the CCC Program will be provided to HP to be forwarded to HID on a quarterly basis.

HID discussed a report which summarized results of intervention letters sent to prescribers for patients who met specific criteria for inappropriate use of controlled substances. Criteria included, the use of short acting opioids for greater than 90 days, utilization of 120 day supply of controlled substances within 90 days and the concurrent use of buprenorphine and another opioid. Over a 6 months period in 2012, a total of 386 patient cases were generated and letters were sent to prescribers of controlled substances. After a 4 to 8 month follow-up period, is was found that 249 patients no longer met criteria for inappropriate use of controlled substances. However, 77 patients continued to have criteria exceptions. The Board asked if results of this nature could be compared and benchmarked against other state Medicaid programs. The Board also recommended that the 77 patients who continued to demonstrate inappropriate use of controlled substances be evaluated to determine if there are any common characteristics

among this group, such as similar prescribers. Also based on prescriber responses, the Board asked if those prescribers who indicated that they would change therapy actually did change therapy for their patients. It was also recommended that the prescribers for the 77 patients be identified to determine which of the CCC practice sites these particular prescribers are associated with. It was also discussed if it would be possible to evaluate prescriber practices at a time period prior to the initiation of the CCC Program (prior to 2009) to determine if utilization patterns and prescribing practices have changed since the implementation of the CCC Program.

The use of antipsychotics in children under the FDA labeled indicated age was discussed. A total of 11 children were identified during the time period of 4th quarter 2012 combined with 1st quarter 2013. This represents approximately 4% of the population of children with claims for antipsychotics during this time period. It was found that 1 patient of the 11 was a foster care child. The Board recommended evaluating the entire population of children with claims for antipsychotics and determining the percentage of these children who are in foster care. The Board also recommended that those children with concurrent claims for antipsychotics and stimulants be identified since antipsychotics may be prescribed only to treat behavioral symptoms, such as agitation, that could be due to adverse effect of stimulants. In addition, the Board recommended that the use of low dose quetiapine in children be evaluated and new criteria be developed to alert prescribers of the potential long term metabolic adverse effects of initiating therapy with atypical antipsychotics in children.

HID noted that 4 patients were found who had a dementia related diagnosis and had claims for antipsychotic agents. HID will continue to monitor this issue.

HID reported that letters were sent to prescribers of rosuvastatin (Crestor®) to inform them that the drug would be non-preferred. However, patients taking the 40mg dose would be able to continue on the drug without the need for prior authorization. The Board recommended that all patients who had claims for rosuvastatin (Crestor®) be evaluated to be certain they have continued on another statin. HP noted that the criteria for approval of rosuvastatin (Crestor®) requires failure of a preferred statin and asked the Board if the criteria should be expanded to include failure of 2 preferred statins. The Board recommended that the criteria should be modified to include failure of a preferred statin and also failure of high dose atorvastatin (Lipitor®).

HID noted that the use of clonazepam has dramatically decreased due to the fact that the drug is now covered under Medicare Part D for the dual eligible population.

HID evaluated available patient diagnosis histories for all patients with at least 6 months worth of claims for oral anticoagulants, including the newer agents and warfarin. There were very few patients to evaluate who had 6 months worth of data for the newer agents. The Board recommended evaluating a shorter time period, perhaps those patients on the drug for at least 2 months.

A list of drugs with the highest cost per claim was evaluated. The Board asked what other state Medicaid programs were doing to manage the use of high cost medications. Some mental health drugs were on the list including, bupropion HBr, paliperidone injectable, risperdone microspheres and modafanil. The Board recommended that prescribers of these drugs be contacted and alerted to the fact that these particular drugs have a higher cost compared to other dosage forms of the same drug or alternate drugs. The Board also proposed that a letter be sent to prescribers of injectable antipsychotics showing the cost of the newer atypical agents and the traditional agents in an effort to educate providers regarding the cost of these injectable medications.

These issues were raised at the P&T Committee earlier and the DUR Board was asked to review the following; utilization of dalfampridine (Ampyra®), use of non-preferred growth hormones and use of non-preferred topical psoriasis treatments. For these drugs it was noted by HP that Medicaid may be the secondary payer. A list of patients

on these drugs will be reviewed to determine if this is the case. If Medicaid is the primary payer, the Board recommended that prescribers of non-preferred growth hormone be notified that alternative preferred agents are available. Prior authorization criteria for dalfampridine (Ampyra®) were also discussed and criteria may be broadened to include contraindications and drug interactions after a more thorough drug information review is conducted. There were also concerns raised regarding patient safety, it is not clear if the drug can be stopped abruptly or if tapering is required.

The next meeting will be held June 4, 2013 at the HP facility.