Division of Health Care, Quality, Financing and Purchasing
Center for Adult Health
Drug Utilization Review (DUR) Board Meeting Minutes
Wednesday April 9, 2008
Electronic Data Systems Conference Room
171 Service Avenue
Cranston, Rhode Island

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

Minor changes where made to the minutes from the December 2007 meeting. Ellen Mauro indicated that 3000 high cost cases have been identified for review, not 300 as incorrectly noted in the draft minutes. Steve Kogut noted that the Rhode Island legislature is initiating legislation that would modify current regulations for filling CII controlled substances to be consistent with new federal regulations.

The utilization of Statins was discussed before and after changes were made to the Preferred Drug List (PDL). There was a noticeable decrease in utilization of Lipitor® since it was made non-preferred and an increase in simvastatin utilization. Dr. Wagner asked if the patients remaining on Lipitor® were those taking the 80mg dose. Patients taking 80mg were allowed to continue without prior authorizations. It was noted that of the 1,667 patients taking Lipitor® prior to the change to non-preferred status, 330 patients no longer had claims for Statins after Lipitor® was made non-preferred. It is possible that some of these 330 patients may have lost Medicaid eligibility or were prescribed other lipid lowering agents.

Steve Kogut raised the issue of lovastatin not being equivalent to other Statins with regard to potency and it should not be considered a first line agent. Doses of less than 40mg per day of lovastatin may not be adequate to provide sufficient lipid lowering effects needed for most patients. Dr. Maxim suggested making lovastatin non-preferred due to its lower potency. Joe Paradis will evaluate claims for lovastatin to determine how many patients are taking 40mg or less per day.

The utilization of antidepressants before and after PDL changes were implemented was reviewed. Dr. Wagner mentioned that the Medicaid PDL differs from the formulary used by the State's prison system and there may be differences in utilization among the various antidepressant agents if these populations were ever compared. With regard to the SSRI class, the use of Lexapro® decreased significantly and there was an increase in the use of citalopram. Patients taking Lexapro® were to be able to continue on the drug without prior authorization. Dr.

Wagner asked if it could be determined if patients taking Lexapro were switched to citalopram or was there an interruption in therapy.

The use of other antidepressants was reviewed. It was noted that the use of Cymbalta® and Effexor XR® were reduced after these agents were made non-preferred. There was an increase in the use of venlafaxine immediate release. There was some discussion as to why Effexor XR® was not given preferred status. Wellbutrin XL® was chosen as the preferred long acting agent in this class by the P&T Committee. It was noted that of 564 patients taking Cymbalta® before its preferred status was changed, only 21 patients were found to have no claims for any antidepressant agent after Cymbalta® was made non-preferred. Board members asked if it is possible that some patients taking Cymbalta® were on duplicate antidepressant therapy prior to the change in the preferred status of the drug. Was it possible that Cymbalta® was discontinued and patients continued on single drug therapy, when some may still have required multiple drug therapy? Joe Paradis will go back and evaluate patients taking Cymbalta® prior to the change in preferred status.

Paula Avarista reviewed recent changes to the PDL. There is currently an average 85% compliance rate with prescribing of preferred drugs. Recent cost savings estimates are that there has been $2.5 million in savings achieved due to changes in utilization to preferred agents and supplemental rebates.

There was discussion about the PDL and how cost effective it is and what impacts switching patients to preferred agents may have. Board members expressed concerns that therapy for those patients taking non-preferred agents may be interrupted or other unintended consequences may result. There was concern that resulting drug cost savings may be offset by other costs. Specifically Board members were concerned about the prior authorization process and how other states are handling the atypical antipsychotic agents. Joe Paradis was asked to present at the next Board meeting how many other states include or exempt the atypical antipsychotic agents from their PDLs. Also if atypical antipsychotic agents continue to be exempt from the PDL in Rhode Island, what others measures can be taken to insure atypical agents are used in a manner that reflects best practices. Interventions such as dose optimization or limiting therapeutic duplication of atypical agents could be evaluated.

Ellen Mauro discussed two programs, Connect Care Choice and Rhody Health Partners. Connect Care Choice has approximately 1,400 patients enrolled. Connect Care Choice is an added benefit to the traditional fee-for-service program. Rhody Health Partners is administered by Unitedhealthcare of New England and Neighborhood Health Plan of Rhode Island. Fee-for-service patients have been automatically enrolled in this program but have the option to stay in the traditional fee-for-service program.

The implementation of using tamper proof Rx pads was discussed. The Rhode Island Board of Pharmacy is considering regulations that would make the use of tamper Rx pads mandatory for all prescriptions filled in the state.

The use of NPI numbers was discussed. As of May 23, 2008 all claims must have a valid prescriber NPI number in order to be processed. NPI numbers are being added to the provider master file by EDS.

The utilization of carisoprodol was discussed. Since the drug metabolizes to meprobamate, many other State Medicaid Programs limit the drug or require prior authorization. Tara Higgins indicated that a prior authorization was implemented by Blue Cross of Rhode Island, but it was recently repealed and now the drug has strict quantity limits. Last month there were 74 patients who had exceptions to the overuse of carisoprodol criteria with an average of about 200 patients on the drug during any given month. The possibility of adding quantity limits on the drug was discussed. Dr. Maxim suggested that patients should not be started on the drug and that other muscle relaxants should be used as first line agents. Dr. Wagner suggested that if limits are added for the drug, all prescribers of the drug should be notified prior to the limits being implemented. Steve Kogut suggested other drug use among carisoprodol users be evaluated, such as narcotics and other drugs with CNS effects.

Tara Higgins briefly discussed a polypharmacy intervention performed by Blue Cross. Patients were identified who were taking ten or more drugs and had three or more prescribers. The prescriber with the highest number of claims associated with their provider number was sent a listing of patients who met the polypharmacy criteria. About 10% of prescribers responded and asked for additional detailed patient information. Tara Higgins will send Paula Avarista the criteria used for this intervention.

Tara Higgins also noted that Blue Cross is evaluating medication reconciliation upon hospital discharge. Steve Kogut mentioned that similar work is being done by the State's Medicare Quantity Improvement Organization, Rhode Island Quality Partners, to evaluate medication reconciliation across patient care settings for Medicare Part D recipients. Ellen Mauro mentioned that the case management nurses perform medication reconciliation upon hospital discharge.

The new Black Box Warning for erythropoietin products was discussed. It was determined that the number of patients taking the drug is very small and that prescribers would have been given ample warning concerning the new safety concerns with the drug from correspondence received from the manufacturer.

Some new criteria were reviewed. Limits on cough products that contain narcotics were briefly discussed. During the review it was noted that Rhode Island currently limits these items to 16 ounces per prescription.

The next meeting is scheduled for Wednesday June 4, 2008 at 8:00am.