Division of Health Care, Quality, Financing and Purchasing
Center for Adult Health
Drug Utilization Review (DUR) Board Meeting Minutes
Wednesday December 3, 2008
Electronic Data Systems Conference Room
171 Service Avenue
Cranston, Rhode Island

DUR Board Members Present:	Tara Higgins, RPh, CGP, CDOE Ray Maxim, MD Richard Wagner, MD
DUR Board Members Absent:	Stephen Kogut, PhD, RPh, MBA 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 September 10, 2008 meeting.

Paula Avarista summarized several recommendations that were made at the Pharmacy and Therapeutics (P&T) Committee meeting held yesterday December 2, 2008. The P&T Committee recommended that the DUR Board evaluate utilization of the following:

- Doses of Vyvanse® greater than 70mg per day.
- Use of anticonvulsant agents for mental health diagnosis. Patient adherence to regimens of anticonvulsant agents appeared to be low based on data presented at the P&T Committee meeting. If adherence is low as reported, patients would be at risk for breakthrough seizures. It is possible that some of these agents are being used off-label for the treatment of mental health indications, such as bi-polar disorder. This may explain why adherence appeared to be low for some of the se agents.
- 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. The question was raised if these combination agents should be covered as combination products single agents only.
- Evaluate duplicate therapy of long acting stimulants.

Health Information Designs, Inc. (HID) will begin to evaluate these areas of drug utilization.

The atypical antipsychotic agents were added to the Preferred Drug List (PDL) in October 2008. Abilify®, Invega® and Zyprexa® are non-preferred. As of October 1, 2008, patients already taking non-preferred

agents were allowed to continue taking them. Patients starting new therapy with an atypical antipsychotic agent after October 1, 2008, are required to start therapy with a preferred agent. Prior authorization can be obtained for non-preferred agents if clinically justified.

In an effort to alert providers, top prescribers of atypical agents were contacted to let them know that the atypical agents would be added to the PDL. It was suggested that discharge planners, administrators and pharmacists at area hospitals be notified as well, to assist with patient treatment and discharge plans in an effort to improve compliance with the PDL with respect to the atypical antipsychotic agents.

There was concern raised that hospitalization rates of patients taking atypical antipsychotic agents should be monitored on a regular basis. If hospitalization rates do increase in the group of patients taking atypical antipsychotic agents, then any savings achieved from adding these agents to the PDL would be offset by increase expenditures on hospitalizations.

Dose optimization of the atypical antipsychotic agents was discussed since there is some cost savings that can be achieved by optimizing doses of these agents due to how various dosage strengths are priced. It was discussed that many patients have their doses titrated which results in them taking what would be considered a non-optimal dose, such as two 5mg tablets as opposed to one 10mg tablet. A suggestion was made to provide a soft edit back to the dispensing pharmacists at the point of service in an effort to improve the use of dose optimization of these agents. If an edit is used, it was recommended that the edit be a soft edit and not a hard edit that would stop the claim from processing and may result in the patients not receiving their medication. It was also suggested that dose optimization could be evaluated for several other classes of drugs.

Therapeutic duplication of antipsychotic agents was discussed. The rate of duplicate therapy in the Medicaid population, as determined by HID criteria, is greater in Rhode Island as compared to other states which contract drug utilization review services from HID such as Connecticut, Maryland and West Virginia. It was recommended that the Community Mental Health Clinic Medical Directors be sent a letter describing the issue of duplicate therapy with antipsychotic agents and be shown data comparing Rhode Island with other states. It was also suggested that top prescribers of duplicate therapy be sent the same letter. It was also recommended that duplicate therapy of antipsychotic agents continue to be monitored.

There was also discussion of patients who were started on an injectable antipsychotic agent who continued taking a concurrent oral agent. There was more concern with continuing educational intervention efforts directed at patients receiving duplicate oral agents as opposed to those receiving an injectable agent along with a concurrent oral agent.

The utilization of narcotics was discussed. It was noted that there are no comprehensive pain management centers in Rhode Island which likely has an impact on narcotic utilization. The utilization of Suboxone® was also discussed. There were a few patients found to have claims for an opioid while taking Suboxone®. The Board agreed that there should be no patient confidentially issues with notifying a Suboxone® prescriber that their patient had received an opioid from another prescriber. However, for patients in Federal drug treatment programs using methadone, primary care providers prescribing opioids, can not be notified that the patient is in a drug treatment program due to strict confidentiality regulations. The Board also recommended reviewing prescribers of Suboxone® to insure that they were all listed on the current registry of approved

Suboxone® prescribers. There was also a recommendation made to look at methadone use in the Medicaid population and determine if it was being used strictly for pain management.

The Board suggested that early refill requests for narcotics should also be evaluated since some patients are likely paying cash for narcotics if they are denied an early refill. It was noted that Rhode Island does have a prescription drug monitoring program to address this issue. However the program needs to be updated.

There was a discussion of the Rhode Island lock-in program. Only those patients who continue to obtain duplicate narcotic agents at several pharmacies are recommended for lock in.

HID was asked to forward to the Department patient names and identification numbers who have multiple criteria exceptions in an effort to determine if these patients would be appropriate candidates for case management.

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