Center for Operations and Pharmacy Management
Drug Utilization Review (DUR) Board Meeting Minutes
Wednesday December 15, 2010

DUR Board Members Present:	Michelle Booth, RPh Stephen Kogut, PhD, RPh, MBA Ray Maxim, MD Ellen Mauro, RN, MPH Richard Wagner, MD
Others Present:	Paula Avarista, RPh, MBA (RI Medical Assistance Program) Ann Bennett (HP Enterprise Services) Karen Mariano, RPh (HP Enterprise Services) Joe Paradis, PharmD (Health Information Designs)

There were no changes made to the minutes from the October 6, 2010 meeting.

Discussion that took place at the most recent P&T Committee meeting was summarized for Board members. Compliance reports are reviewed at the meetings. These reports show the number of claims and number of patients taking medications from a particular class of drugs over the previous 3 month time period. Based on review of these reports, it is often the case that there are fewer claims than would be expected based on the number of patients taking the drugs. It appears that patient adherence is an issue with many drug classes which would be considered maintenance drugs. Several drug classes including stimulants and drugs for Alzheimer's were reviewed at the most recent P&T Committee meeting. Some explanation for this may be that when new patients are enrolled into the Medicaid Program they are in the fee-for-service population for a very short time before they are enrolled in Managed Care. HID will evaluated the utilization of stimulants and drugs to treat Alzheimer's and determine the average days supply dispensed per patient over a 3 to 6 month time period.

The issue of patient adherence was further discussed by Board members and the following drug classes were noted to be of significant concern with regard to adherence; antidepressants, antihypertensive agents, medications for the treatment of diabetes and lipid lowering agents.

Provider compliance with regard to prescribing non-preferred drugs, specifically duloxetine (Cymbata®) and pregabalin (Lyrica®) was discussed at the most recent P&T Committee meeting. Both of these drugs have complicated prior authorization criteria that involve review of previous drug and diagnosis history criteria.

The P&T Committee recommended adding a step edit for the use of an angiotensin receptor blocking agents (ARBs) that would involve failure of an angiotensin converting enzyme inhibitor (ACE). Board members noted that there is no benefit to concurrent therapy of an ACE and an ARB and asked HID to determine if any patient were on dual therapy.

There was discussion regarding the prospective DUR system. It was noted that the pharmacist do not need to override claims for late refills, low dose and high dose alerts. However, therapeutic duplication alerts and alerts for drug-drug interactions and early refills require a pharmacist's override. Pharmacist overrides are allowed without a required call to a prior authorization call center help desk since there is no 24 hour call center in Rhode Island. It was also noted that drug and diagnosis claims cannot be coordinated by a prospective DUR system unless diagnosis information were submitted along with the drug claim. Some claims processing systems do allow for diagnosis data to be transmitted with a drug claim. The Board asked if any data could be provided from other states that require prior authorization calls for specific prospective DUR alerts to determine the percentage of calls for overrides that are approved or denied.

The use of low dose quetiapine was discussed. Many issues were discussed including the off label use of low dose quetiapine for sedation or anxiety, the black box warning for use in dementia, alternative agents for insomnia, non drug behavioral techniques for treatment and the use of alternative atypical agents such as risperidone. The Board asked if it were possible to identify patients who appeared to be taking the drug once daily for insomnia vs. those taking it as needed for anxiety. Would it also be possible to identify the top prescribers of low dose quetiapine and contact them to determine for what indications they most commonly are prescribing the drug. Individual DUR alert letters should continue to be sent to prescribers and if possible try to determine for what indication the drug is being prescribed.

It was also noted that low dose quetiapine is often used as an adjunct agent to existing atypical antipsychotic therapy. Poly-pharmacy with antipsychotics is a new Joint Commission indicator that will require long term care facilities to report the number of patients on multiple agents.

The use of low dose quetiapine in the Community Medication Assistance Program (CMAP) was also discussed. In the past the use of low dose quetiapine was more tightly controlled for CMAP patients. Currently there are no controls on the use of the drug and CMAP utilization of low dose quetiapine is similar to the Medicaid population. Although this is not a Medicaid Program, it will be determined if CMAP patients can be included in DUR mailings for low dose quetiapine.

There was some discussion regarding the doughnut hole with respect to Medicare Part D plans. Some patients cannot afford to have prescriptions filled once they reach the threshold for the doughnut hole. The new healthcare reform act will eventually close the doughnut hole by the year 2020.

The utilization of triazolam was discussed. Board members noted that since the drug could cause both retrograde and anterograde amnesia it should not be used. Even the use of other benzodiazepine sedatives would be preferable to triazolam. The Board recommended that prescribers of triazolam be identified and that DUR letters be sent as well as considering prior authorization criteria for the use of the drug.

HID informed the Board that DUR intervention letters were sent for 18 patients found to be taking omeprazole (Prilozec®) or esomeprazole (Nexium®) and clopidogrel (Plavix®) to alert them with respect to the drug interaction for these agents.

The use of clonazepam with another benzodiazepine was discussed. The Board noted that there would be no clear indication for using multiple benzodiazepines and asked if prescribers of duplicate benzodiazepine therapy could be identified.

The use of atypical antipsychotic agents in children who are younger than the lowest age noted as an FDA approved indication was evaluated. There were 25 patients found and the Board asked if the prescribers could be identified. The Department requested that HID provide detailed patient drug and diagnosis history profiles for these children and submit them to the Department for review.

The Department noted that every year the DUR program is discussed as part of an audit of the Medicaid Program. There is concern regarding the response rate to DUR letters. Auditors are interested in what the Department is doing to try to improve responses from prescribers. The possibility of calling prescribers who do not respond has been discussed. HID will share with the Department response rates from other states and also provide the Department with actual comments received on the response forms from prescribers.

Several specific Black Box Warning criteria were discussed. Board members asked for those criteria which involve potential liver toxicity could actual laboratory data for evaluated. It would only be possible to determine if patients had blood tests performed but actual lab results would not be available. It was also noted that for specific criteria minimum and maximum patient age limits could be set in the prospective DUR system.

The next meeting will be held on March 2, 2011.