Executive Office of Health and Human Services

RI Department of Human Services

DRAFT Drug Utilization Review (DUR) Board Meeting Minutes

Date - Tuesday, December 11, 2012
Meeting - 10:30 AM

DUR Board Members Present:	Stephen Kogut, PhD, RPh, MBA Ellen Mauro, RN, MPH Richard Wagner, MD
DUR Board Members Absent:	Michelle Booth, RPh Ray Maxim, MD 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) Ralph Racca (Rhode Island Medicaid)

Minutes from the August 28, 2012 meeting were approved with minor changes.

There was discussion raised by DUR Board members regarding the operations of the P&T Committee and the DUR Board with respect to having members from the two committees being invited to attend both meetings. It was also suggested that members of the Medicaid Advisory Committee be invited to attend both the P&T Committee and DUR Board meetings. Board members also asked if the role of the new Medicaid Medical Director could also be clarified with respect to attendance at P&T Committee and DUR Board meetings.

At the August DUR Board meeting, the number of children found with claims for antipsychotics under the labeled indicated age was discussed. There is ongoing concern that foster care children may have a higher prevalence of use of antipsychotics as compared to other children. There were 18 children identified in August and upon follow up by HP it was determined that none of those children were foster care children. This issue will continue to be followed at future meetings.

Several issues that were raised at the P&T Committee meeting, which was held earlier this morning, were discussed. The first was regarding the non-preferred status of Crestor®. Board members questioned why Crestor® was recommended by the P&T Committee to become non-preferred. The availability of generic Lipitor® has made that agent the preferred higher potency statin. The P&T Committee recommended that prescribers of Crestor® be notified of the change so that therapy would not be interrupted. Patients taking the 40mg dose would be allowed to continue. However, all other patients would need to switch to another statin. There were approximately 30 patients found to have claims for the drug. It was decided that HID would send a letter to prescribers prior to the change in status which could be as early as January 1, 2013.

Clonazepam was removed from the anticonvulsant drug class by the P&T Committee and the Committee asked the DUR Board to review the utilization of the drug. The drug will not be part of the PDL and remains available without restriction. Board members recommended that HID evaluate the use of clonazepam and if possible determine the number of patients taking the drug and the percentage of them that have some kind of seizure diagnosis. Also determine how many patients are 65 or over to estimate how many are enrolled in Medicare Part D plans.

The P&T Committee also recommended that the DUR Board evaluate the use of anticoagulants. Warfarin is the only preferred oral agent at this time. The newer oral anticoagulant agents require prior authorization. Board members asked if HP could determine the cost associated with warfarin laboratory monitoring. Board members also asked if patients who may have been discharged on one of the newer oral agents could be continued on the drug. HP noted that prior authorization for one of the newer agents would be approved if the patient were discharged from the hospital on the drug. The Board asked HID to identify patients taking warfarin for up to 12 months and evaluate their diagnosis data to look for evidence of bleeding and to do the same for patients taking any of the newer oral agents chronically as well. They asked that results for stratified by age and gender.

The Board asked HID to inquire with other states if they placed restrictions on the use of angiotensin modulating combination agents and if they preferred the use of the combination agents or single agents. The Board also asked HID to evaluate the use of the antipsychotic Latuda® and determine if it is being used in pregnant patients.

HID discussed DUR letters sent over the past quarter with respect to screening for overuse of controlled substances and the lock-in program. HID presented data on the use of Suboxone® and other opiods and the use of short acting agents for more than 90 days. Only one (1) patient was found to have ongoing concurrent claims for Suboxone® and other opioids. It appeared that after intervention letters were mailed the number of patients found to continue utilizing short acting agents chronically was reduced. HID will prepare a detailed report of the findings.

Since January 2012, twenty (20) patients have been identified as potential lock-in candidates, and prescribers and patients received intervention letters stating if utilization did not improve that the patients would be restricted to a single pharmacy. Of those patients, six (6) of them went on to be recommended for lock-in. HP has determined that all six (6) patients recommended for lock-in are patients enrolled in the Rite Share Program. For Rite Share patients, Medicaid is the second payer and the first payer is the patient's primary insurance. There was discussion regarding whether copies of DUR lock in alert letters for Rite Share patients should also be sent to the primary insurance plan. Board members were concerned that if letters were sent to the insurance plan, patient may be stigmatized. However, it was also noted that identifying the appropriate contact person at the primary insurance plan was not always possible.

Board members noted that a statewide comprehensive plan to reduce abuse of opioids would be the best strategy to pursue. However, the problem of statewide abuse of opioids may be beyond the scope of the Medicaid DUR Board. HP noted that pharmacists do have access to the Prescription Drug Monitoring Program. HID was asked to continue to screen for opioid abuse among Medicaid recipients and recommend patients for lock-in to HP for further evaluation. HID noted that in Maryland, the DUR Board reviews individual cases and makes recommendations for patients to be locked-in.

It was made known that the Connect Care Choice Program has a lock-in program that can restrict patients to a single pharmacy. Multiple emergency room use is one criteria used to screen for patients. A list of patients restricted under this program will be obtained so the HID can determine if they have identified some of the same patients.

HID reported that 10 children were found who had claims for antipsychotic agents who were under the labeled indicated age for their use. A list of patients will be provided to HP for further evaluation. HID was also asked to evaluate the use of low dose quetiapine in children as well since it is used as a sedative agent in children with ADHD.

HID reported that four (4) patients over age 65 with a diagnosis of some form of dementia were found to have claims for antipsychotic agents. HID was asked to evaluate these claims and determine if the claims were processed by long term care pharmacies in an effort to determine if these were long term care patients.

HID reported that there are currently no patients with current claims for the newer protease inhibitors indicated for the treatment of *hepatitis C*. HID also reported that there were no claims for androgen use in woman and a small number of claims used in patients less than 21 years of age. HID was asked to continue monitoring these two issues periodically.

HID presented a list of medications with the highest cost per claim. The Board recommended that HID prepare a listing of non-preferred agents with the highest cost per claim. In the future it may be useful to alert prescribers of these high cost non-preferred agents and recommend that preferred agents be utilized if clinically indicated.

It was noted in evaluating top individual drugs by number of claims that four (4) of the top ten (10) drugs were benzodiazepines.

The issue of methadone use was discussed. The DUR Board recommended that prescribers of methadone be altered to the need for routine EKG monitoring in their methadone patients.