Executive Office of Health and Human Services

RI Department of Human Services

Drug Utilization Review (DUR) Board Meeting Minutes

Date – Tuesday, June 3, 2014

Time – 10:30 AM

DUR Board Members Attending:	Michelle Booth, PharmD Stephen Kogut, PhD, RPh, MBA Ellen Mauro, RN, MPH Linda Rowe Varone, PharmD, BCPP Richard Wagner, MD
Others Attending:	Ann Bennett (HP Enterprise Services) Cathy Cordy, RPh ((Rhode Island EOHHS) Jerry Fingerut, MD (Xerox) Karen Mariano, RPh (HP Enterprise Services) Ralph Racca (Rhode Island EOHHS) Joe Paradis, PharmD (Health Information Designs – HID) Jenifer Sternick (Rhode Island EOHHS)

Minutes from the April 8, 2014 meeting were approved with minor changes.

The lock-in program and monitoring of the use of opioids were discussed. Currently, 92 patients are enrolled in the Connect Care Choice (CCC) pharmacy lock-in program. These patients are restricted to a single pharmacy and are assigned to a primary care provider. It was recommended that primary care providers be notified when patients are restricted to a single pharmacy.

The question arose if Managed Care Organizations (MCOs) are notified when patients are first enrolled in Medicaid fee-for-service and are found to be over-utilizing controlled drugs prior to the time that they are enrolled in an MCO. Currently this is not done. However, in other States HID uses a referral letter to alert MCOs. HID will share a sample of an MCO referral letter from another State Medicaid program with HP. It was noted that the Neighborhood MCO must have two quarters of utilization data before it can act to restrict a patient to a single pharmacy.

At the April meeting there was discussion regarding criteria that would result in the patient being restricted to a single pharmacy. Those criteria are; patients receiving 6 or more claims for controlled substances from 3 or more pharmacies and 2 or more prescribers in the most recent 30 days. HID was asked to determine how many patients met this criteria in recent months. It was found that during the first quarter of 2014, 12 patients met these criteria. Going forward HID will refer these patients to HP for referral on to the CCC program for lock-in consideration. Hospice patients would not be included for referral.

HID developed proposed language to add to all DUR letters that address overuse of controlled drugs which recommend prescribers utilize the Prescription Drug Monitoring Program (PDMP). The language will be added to DUR letters going forward.

There was further discussion regarding the PDMP. There was a discussion about revising the prior authorization criteria for non-preferred opioids and mandate that prescribers access the PDMP and review the patient's utilization before an authorization for a non-preferred opioid agent is granted. This would require all prior authorizations to be done manually. Suggest continued discussion at the August meeting. Currently some of the approvals are automated based on patient prior history and use of a preferred agent. Requiring prescribers to evaluate the PDMP before providing prior authorization has no legal standing at this time. There is also legislation pending that will require that providers enroll in the PDMP prior to being able to obtain a controlled substance license. There is also pending legislation that would allow delegates of a provider to access the PDMP on their behalf. The issue of requiring PDMP registration for Medicaid providers will be brought up again in at the August meeting.

It was noted that the Neighborhood MCO is considering sending intervention letters to prescribers for patients who are using multiple prescribers to obtain opioids and those with doses higher than 120mg morphine equivalents. The letter would recommend the prescriber access the PDMP to review patient histories.

HID presented a summary of patients who met a criteria for long term use (greater than 90 days) of short action opioids. A total of 56 patients met the criteria and had intervention letters sent to their prescribers. After a three month follow-up only six patients were identified by the criteria again. However, eligibility of patients was not determined; many patients may have transferred to MCOs or lost eligibility. A few prescribers were found to have more than one of their patients meet the criteria. It was recommended that these prescribers be identified.

The availability of naloxone at Walgreens pharmacy was discussed. HID suggested that letters be mailed to prescribers of opioids regarding the availability of the drug. However, several outreach letters have been mailed to providers and the availability of the drug is widely known in the provider community, no further outreach was recommended. There was a question regarding patients who are restricted to other pharmacies, not Walgreens. These patients could obtain naloxone from their assigned pharmacy since it is covered by Medicaid or they could obtain naloxone at no charge from any Walgreens through the collaborative practice agreement that has been established.

The use of opioids with buprenorphine/naloxone (Suboxone®) was discussed. A small number of patients each month are noted to have a concurrent opioid claim with buprenorphine. Only the buprenorphine prescribers would be alerted to the duplicate therapy. There are federal regulations under 42 CFR that prohibit disclosing that a patient is enrolled in a drug treatment program. HID shared information that other State Medicaid DUR programs consider this a therapeutic duplication alert. The Neighborhood MCO is alerting prescribers of buprenorphine that patients have claims for other opioids.

A summary of the use of antipsychotics in children under the labeled indicated age was presented by HID. Data are consistent with previous quarters. According to the American Academy of Pediatrics, short term use of antipsychotic in specific children may be beneficial. However, long term use requires more consideration due to the potential for long term adverse effects including metabolic effects. It was recommended that prescribers for all patients under age 18 who start new therapy on an antipsychotic agent be alerted to the cautions associated with long term use of antipsychotic agents.

The use of agents to treat hepatitis C was discussed. Rhode Island Medicaid is developing prior authorization criteria for the use of the new hepatitis C agents that would be used for fee-for-service

and MCO patients. HP will be tracking all patients for adherence and length of therapy. Prescribers will be evaluated based on how many of their patients complete a full course of therapy. If patients begin therapy while enrolled fee-for-service, treatment will be continued if they are enrolled in an MCO.

The issue of non-adherence to antiretroviral therapy was discussed. A limited number of patients obtain antiretroviral agents through the fee-for-service Medicaid program. For those that do, very few are found to meet non-adherence criteria which measures utilization less than 90% of expected use. It will be determined if prescriber intervention letters can be sent to prescribers for these patients. The concern is that if an incorrect prescriber number is associated with the claim, the letters may disclose to providers that the patient is HIV infected.

The long term use of alendronate over five years has been associated with treatment failure and an increased occurrence of fractures. HID evaluated a small number of patients who had claims for alendronate five years ago and also had current claims for the drug. Six patients from the group of 17 patients had a history of recent fracture. It was recommended that prescribers for patients on long term alendronate be alerted to the risk of treatment failure.

A review of the use of non-preferred growth hormone had been requested by the P&T Committee. Four patients where found out of 13 total with claims for growth hormone who had claims for non-preferred agents.

Review of the use of the new SGLT-2 inhibitors was requested by the P&T committee. There were no recent claims for these agents found. HID will continue to monitor use of these agents.

HID presented criteria adopted by other State Medicaid programs that alerts prescribers of patients with a diagnosis of diabetes who have no paid claims for agents to treat diabetes in their recent claims history. It was recommended that these intervention letters not be mailed to prescribers.

HID presented a review of black box warning criteria. These criteria alert for drug-drug and drug-disease interactions that are noted in the black box warning section of the drug label. The highest number of alerts are associated with the use of oxycodone and CYP3A4 enzyme inhibitors which may result in higher plasma levels of oxycodone to be observed. It was recommended that these letters be sent each time the alert is noted even if the interacting drugs are only used concurrently for a short period of time. It was noted on responses to DUR letters that three patients were deceased. HID will follow up with HP and determine if diagnosis data would indicate if these were patients with cancer or perhaps were hospice patients.

HID presented an overview of DUR letters mailed during the first quarter of 2014. Response rates remain consistent from previous quarters at 37%. Response rates have ranged from 31% to 44% in the past.

Two issues were discussed at the P&T Committee meeting which occurred just prior to the DUR Board meeting, and the Board was asked to consider the follows:

1. Review of patients with higher doses than recommended for eszopiclone (Lunesta®) based on recent FDA warning.
2. Evaluate the need for quantity limits for emergency epinephrine devices (EpiPen®).

It was recommended that HID evaluate the use of eszopiclone (Lunesta®) and alert prescribers of patients with claims for the higher doses. HID will also evaluate the use of EpiPen®.

The next meeting will be held August 26, 2014.